

S-600

67 5001

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 5001

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY LOUIS SERRA

2. DATE AND HOUR PRONOUNCED DEAD

May 21, 1967

1:31 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)33
99

Johns Hopkins Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

BALTIMORE Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1917 Ellinwood Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

March 8, 1944

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lease operator (trucking)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Alan Dwight Serra

14. MOTHER'S MAIDEN NAME

Mary Ann Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-44-6371

17. INFORMANT

ADDRESS

Mrs. Laura L. Serra 1917 Ellinwood Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Multiple traumatic injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Kenwood Avenue and Trump Mill Road

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

5-21-67 12:46 A.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of car which hit pole

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 21, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/24/67

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, County, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

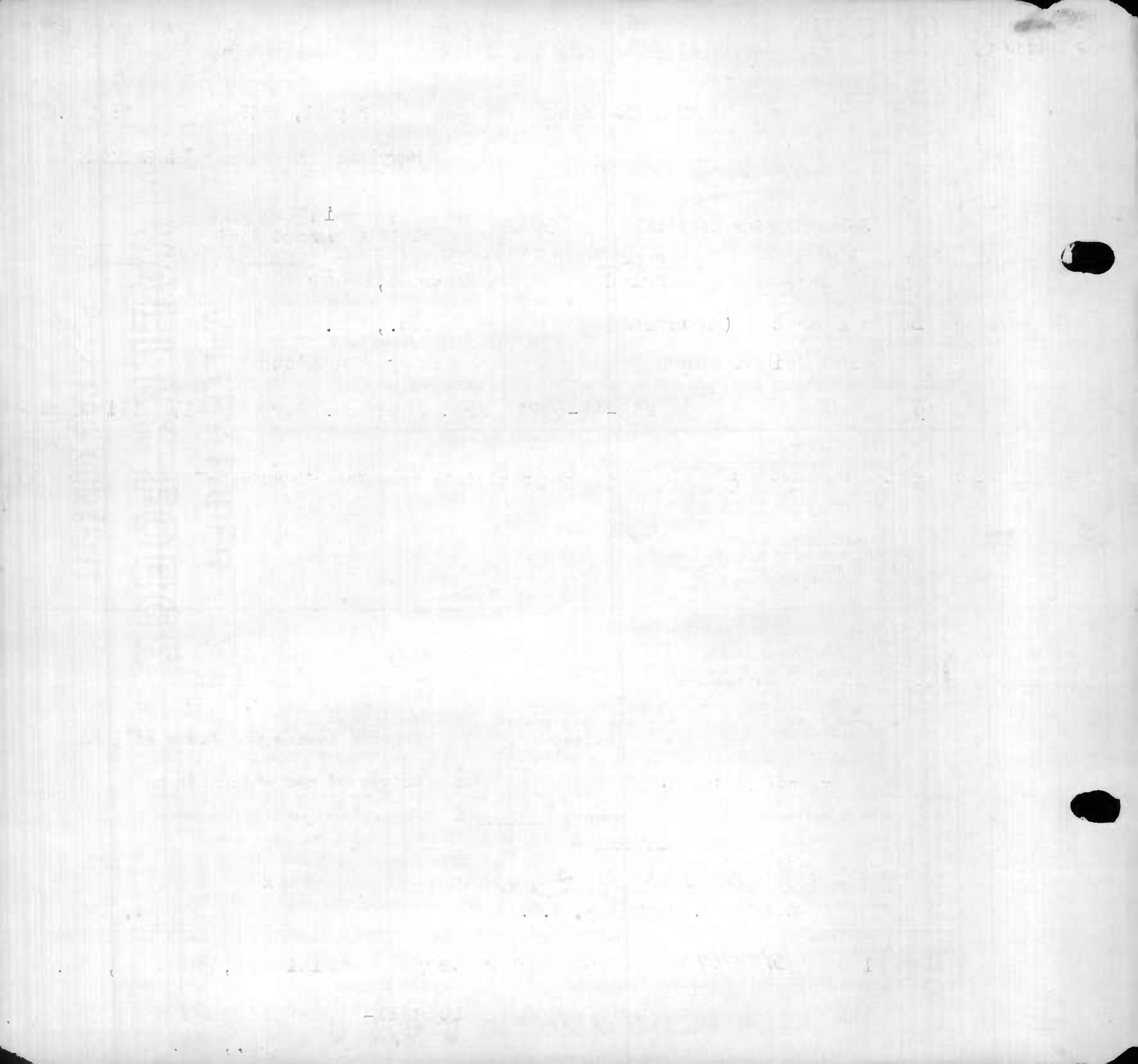
24C. FUNERAL DIRECTOR

ADDRESS

MAY 24 1967

G. O. B. E. F. A. M. A.

Mitchell-Wiedefeld Home 6500 York Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5002					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 5002				
1. NAME OF DECEASED (Type or Print) EDWIN J. KIRBY					2. DATE AND HOUR OF DEATH May 21st, 1967 4 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital					A. STATE B. COUNTY Maryland				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 1711 East 32nd Street				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/29/1907	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor			10B. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Kirby					14. MOTHER'S MAIDEN NAME Mary Ann McGinnis				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 215-05-4712		17. INFORMANT Mr. Edwin J. Kirby, Jr (Son)		ADDRESS 98 Murdock Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH Atherosclerotic Heart Disease Acute coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 1 yr. 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 10 1966 to May 21 1967, that (I) (we) last saw the deceased alive on May 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE G. J. Sawyer, M.D.					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/22/67		
23C. PHYSICIAN'S NAME (Type) G. J. Sawyer, M.D.					23D. ADDRESS 4808 Harford Rd.				
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 5/24/67		24C. NAME of CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Balto. County, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR G. J. Sawyer		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld		ADDRESS 6500 York Rd. Balto., Md. 21212			

7. 1. 1. 1. 1.

2. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

1. 1. 1. 1. 1.

BIRTH NO. 67 5003		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5003	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) FLOYD LEESON, Jr.			2. DATE AND HOUR PRONOUNCED DEAD May 19, 1967 11:00 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 706 Ann Street		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH June 4, 1924	9. AGE (In years last birthday) 42	If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10B. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Parkersburg, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Floyd Leeson, Sr.		
14. MOTHER'S MAIDEN NAME Mable Malone		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11			
16. SOCIAL SECURITY NO. 215-14-8005		17. INFORMANT Mrs. Opal Smith (sister) Box 1240 Rt. #2 Crownsville, Md.			
18. CAUSE OF DEATH E 903.5, 4322.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) Cerebrocranial injuries DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute ethylism					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidewalk		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 1856 Wilkins Avenue - Ginney Jims Gin Mill	
21D. TIME OF INJURY (APPROX.) 5-19-67 8:16 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell on sidewalk 19-04	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 20, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE May 23, 1967		23C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
		23D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
24A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		24B. NAME OF REGISTRAR Robert E. Williams		24C. FUNERAL DIRECTOR Eugene B. Fleming	
		24D. ADDRESS Singleton Funeral Home		Glen Burnie, Md.	

APRIL 11 1917

WILLIAM MORRIS

John W. Morris

CERTIFICATE OF DEATH

Registered No. 67 5004

BIRTH NO. 67 5004

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Andrew Linus Duerling

2. DATE AND HOUR OF DEATH

5-14-67 830 4 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Md. 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore Co.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3128 Willoughby Road

21234

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widower

8. DATE OF BIRTH

12-7-1892

9. AGE (In years
last birthday)

74

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George A. Duerling

14. MOTHER'S MAIDEN NAME

Catherine Wright

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

218-10-0189

17. INFORMANT

ADDRESS

Records: BCH 4940 Eastern Avenue 21224

18. 526X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A)
DUE TO

Pneumonia

10 days

(B)
DUE TO

Chronic bronchitis + emphysema

UNKNOWN

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11 15/ to 5/14 19 67.
that (I) (we) last saw the deceased alive on 5/14 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

R. Tarsey

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5-14-1967

23C. PHYSICIAN'S
NAME (Type)

D. Tarsey

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-645

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5005				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5005	
1. NAME OF DECEASED (Type or Print) MACHOVEC, JOSEPH JAMES				2. DATE AND HOUR OF DEATH 5/11/67 9:45 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				A. STATE MARYLAND B. COUNTY BALTIMORE			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-03			
				D. STREET ADDRESS (If rural, give location) 3914 DUDLEY AVENUE			
5. SEX MALE	6. RACE CAUCASION	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9/30/04	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN			10B. KIND OF BUSINESS OR INDUSTRY RED CROSS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME FRANK MACHOVEC				14. MOTHER'S MAIDEN NAME ANNA VAROCK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 10-1-26 TO 5-31-28			16. SOCIAL SECURITY NO. 218-16-0930		17. INFORMANT RECORDS ADDRESS V. A. HOSPITAL, BALTIMORE, MD. 21218		
18. CAUSE OF DEATH 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 2 days			
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 5, 1967 to MAY 11, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 11, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <i>David N. Marine</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 12, 1967	
23C. PHYSICIAN'S NAME (Type) DAVID N. MARINE				23D. ADDRESS M.D. V. A. HOSPITAL, BALTIMORE, MARYLAND 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/15/67		24C. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL Cem		24D. LOCATION (City, town, or county) (State) BALTO MD.	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR <i>Robert E. Hoffman</i>		25C. FUNERAL DIRECTOR <i>Robert E. Hoffman</i>		ADDRESS 6667 Harford Rd	

AVT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5006		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5006	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Julia Lee Arnold		2. DATE AND HOUR OF DEATH May 21, 1967 15:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Anne Arundel Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		D. STREET ADDRESS (If rural, give location) 301 Church St.		52-00	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 11-29-94	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home Maker		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Gray		14. MOTHER'S MAIDEN NAME Josephine Jordan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-56-4315		17. INFORMANT Mrs Florence Snyder	
18. 443X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Intracranial Bleeding (probable) DUE TO		(B) Hypertensive A.S.C.V.D. DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 5-18 19 67 to 5-21 19 67 , that (I) (we) last saw the deceased alive on May 21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE David J. Steinbauer M.D.	
23B. DATE SIGNED 5/21/67		23C. PHYSICIAN'S NAME (Type) David J. Steinbauer M.D.		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 24, 1967		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Hwy, Balto, Md 21225		25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Robert E. Steinbauer	
25C. FUNERAL DIRECTOR George J. Gonce		25D. ADDRESS 4001 Ritchie Hwy, Balto		25E. ADDRESS	

March 1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

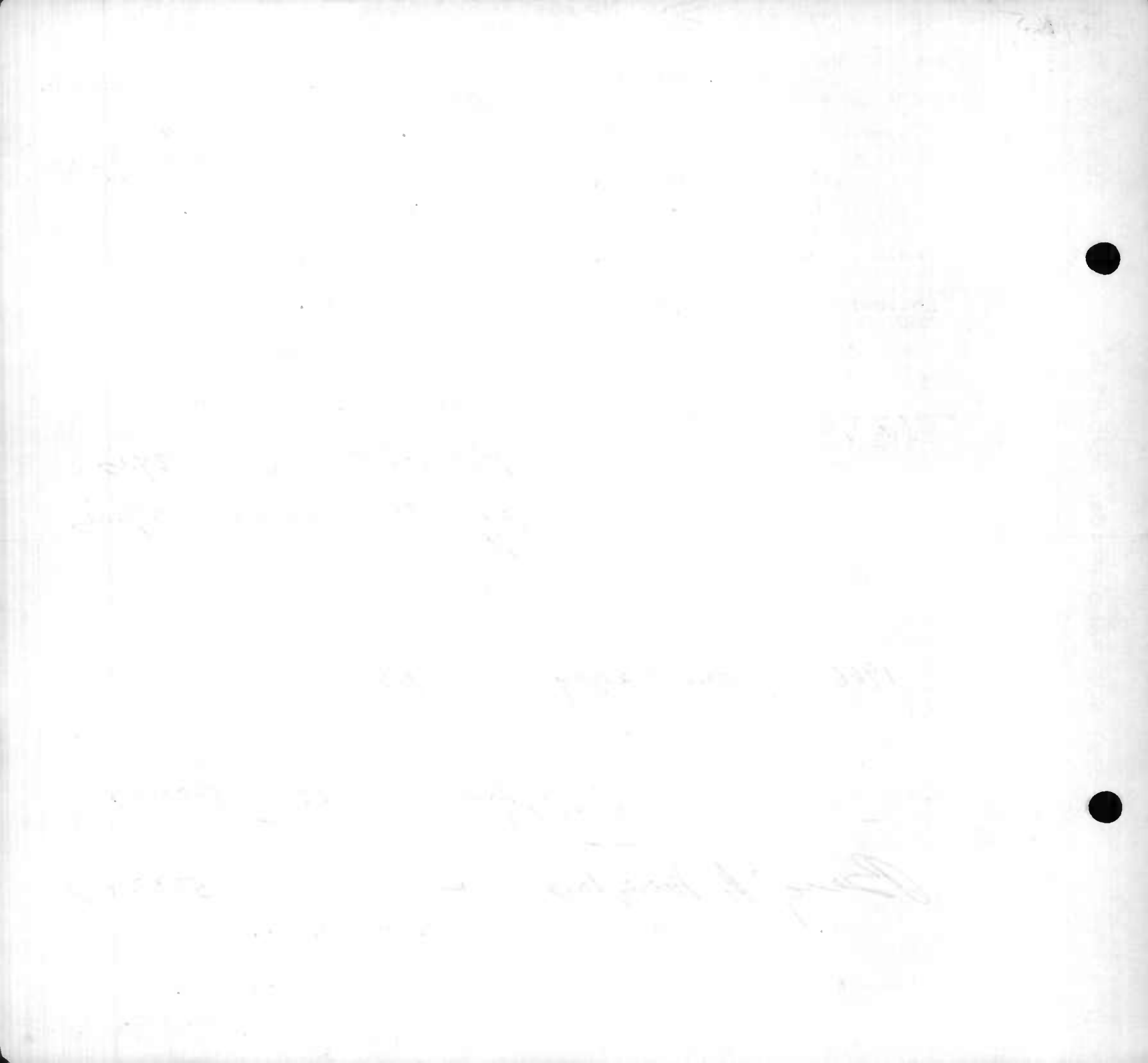
1941

1941

FUNERAL DIRECTOR: IMPORTANT

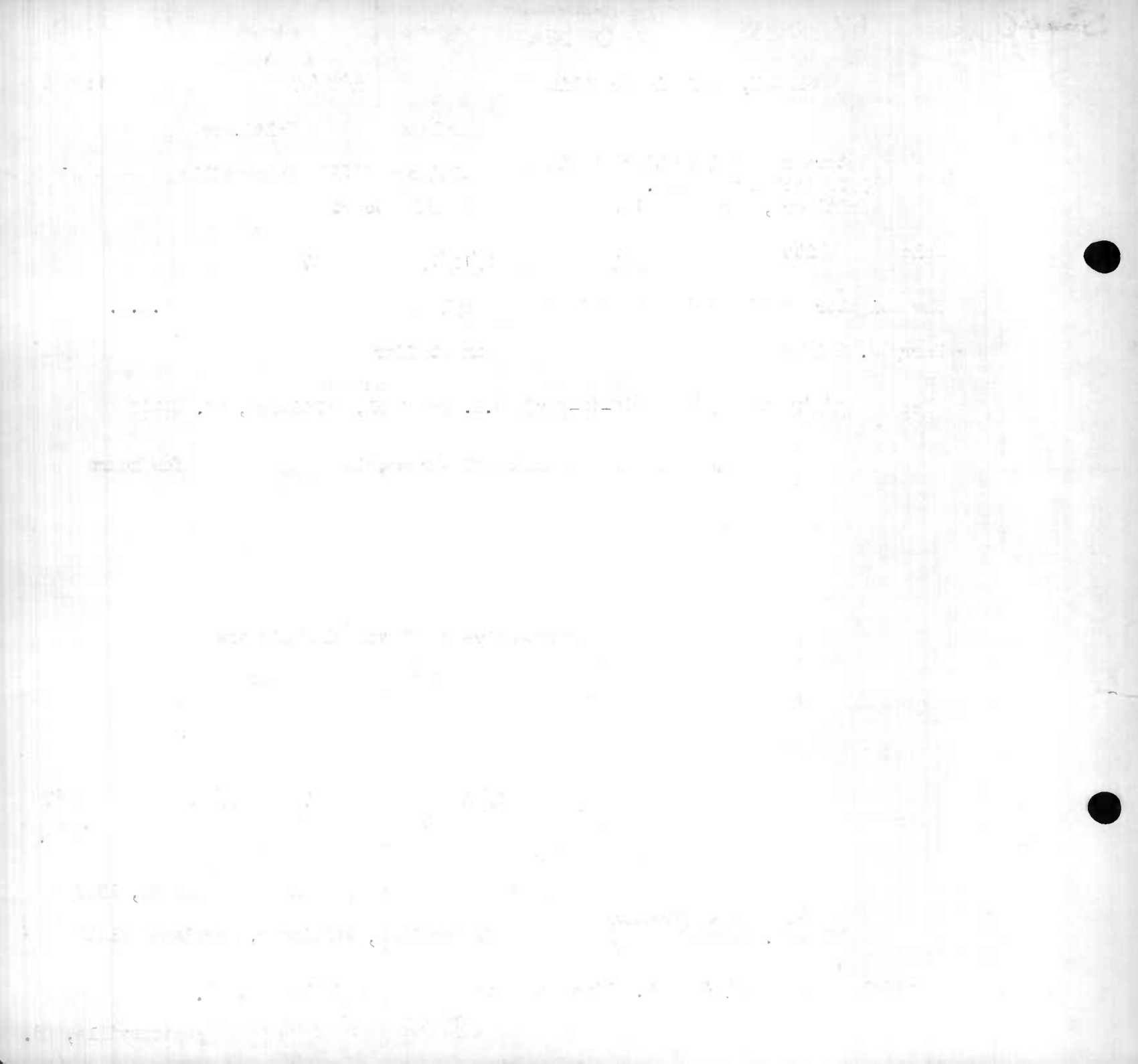
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5007				BALTIMORE CITY DEPARTMENT		Registered No. 67 5007	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARY A. SULLIVAN				2. DATE AND HOUR OF DEATH May 20, 1967 6:30 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 411 N. Montford Ave. Baltimore, Md., 21224				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 411 N. Montford Ave.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed		8. DATE OF BIRTH 10/5/98	9. AGE (In years last birthday) 68	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Schmitt				14. MOTHER'S MAIDEN NAME Margaret Zorn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-48-6088		17. INFORMANT Evelyn Petr, dght, above		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Breast cancer ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive C.V.D.'s				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 29 1/2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast-Biopsy		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN. 1965 to 5-20-67 19 that (I) was last saw the deceased alive on 5-20-67 19 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.							
23A. SIGNATURE Benjamin Moses, M.D.				23B. DATE SIGNED 5-23-67		23C. PHYSICIAN'S NAME (Type) Dr. Benjamin Moses	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/24/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR R. E. G. G. G.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

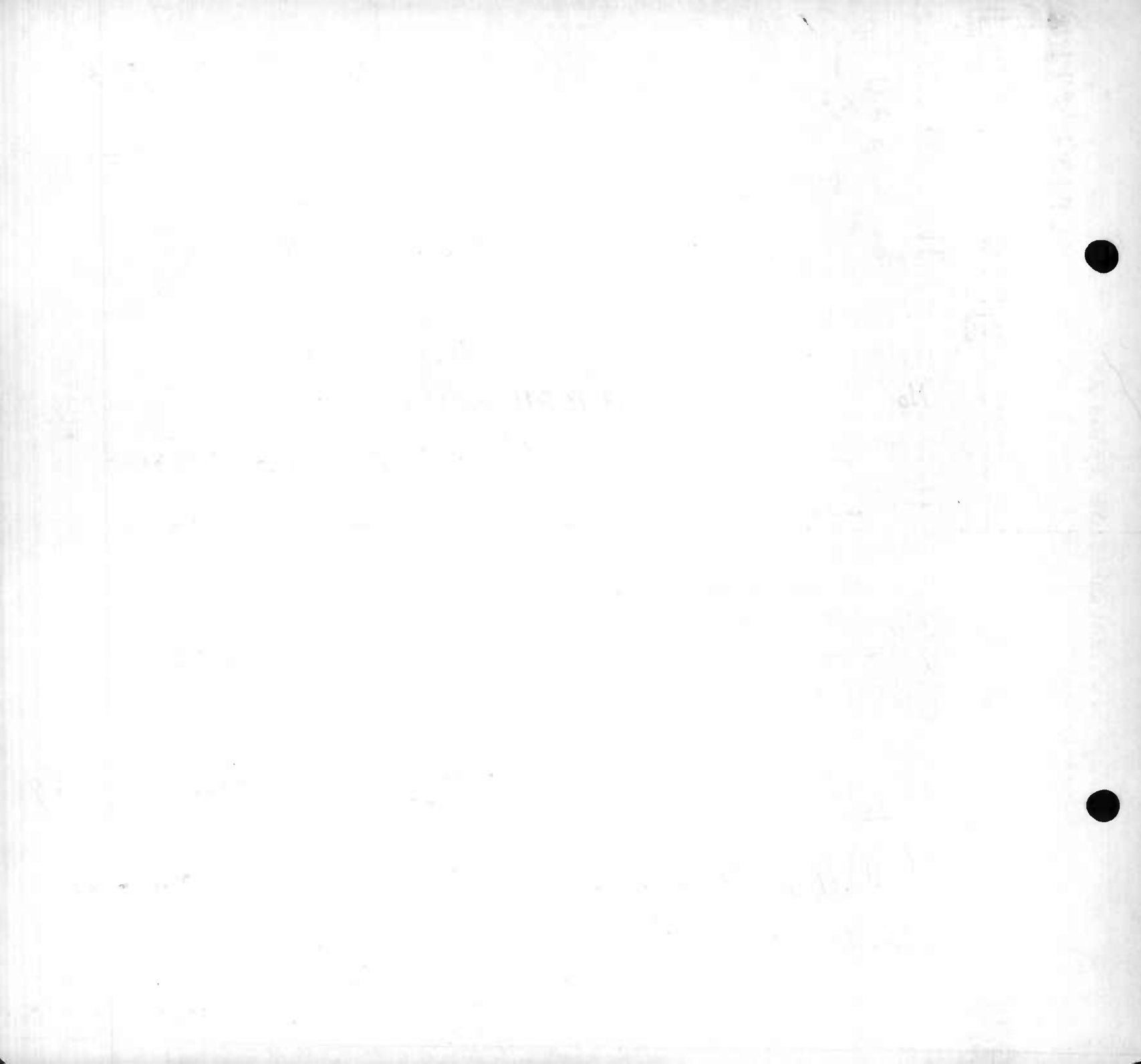
BIRTH NO. 67 5008		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5008	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SHIPLEY, Benjamin Franklin		2. DATE AND HOUR OF DEATH 5/22/67		1:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C.			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21228 Catonsville 53-00			
		D. STREET ADDRESS (If rural, give location) 30 Arkla Court			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/10/1900	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investigator Fraud		10B. KIND OF BUSINESS OR INDUSTRY State of Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry F. Shipley		14. MOTHER'S MAIDEN NAME Ann Staffer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5/7/17 to 3/7/18		16. SOCIAL SECURITY NO. 219-12-5688		17. INFORMANT Records V.A. Hospital, Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 332X1 Cerebral thrombosis DUE TO		CAUSE OF DEATH (A) Cerebral thrombosis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH few hours	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive cardiovascular disease			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 2/24 19 67 to 5/22 19 67 that (I) (we) last saw the deceased alive on 5/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ralph H. Twining		23B. DATE SIGNED May 22, 1967			
23C. PHYSICIAN'S NAME (Type) RALPH H. TWINING		23D. ADDRESS VA Hospital, Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/24/1967		24C. NAME of CEMETERY or CREMATORY Mt. Olive Cemetery	
24D. LOCATION (City, town, or county) (State) Randallstown, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR R. E. Twining	
25C. FUNERAL DIRECTOR Easton Funeral Home		ADDRESS Catonsville, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5009		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5009	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Lucille D. Albright		2. DATE AND HOUR OF DEATH May 20 1967 10 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 001308 Appleby Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-15 D. STREET ADDRESS (If rural, give location) 1308 Appleby Ave			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Aug 29 1907	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Clinton W Albright		14. MOTHER'S MAIDEN NAME Daisy Cox			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218 18 5611		17. INFORMANT Mrs J. Leonard Stern	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-Vascular Disease		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1951 to May 20 1967, that (I) (we) lost saw the deceased alive on May 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.					
23A. SIGNATURE William G. Helfrich M.D.				23B. DATE SIGNED May 22 67	
23C. PHYSICIAN'S NAME (Type) William G. Helfrich		23D. ADDRESS 5006 Roland Ave M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-23-67		24C. NAME of CEMETERY or CREMATORY Woodlawn Cem	
24D. LOCATION Woodlawn Bldg Co MD		24E. FUNERAL DIRECTOR Burgess Funeral Home			
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. ADDRESS 3631 Falls Rd Balt	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5010		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5010	
M.E. CASE NO.		DOUGLAS S. WILLIAMS		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		Douglas S. Williams		2. DATE AND HOUR OF DEATH May 21st 1967 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		A. STATE MD B. COUNTY Baltimore Co.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville 33-00			
		D. STREET ADDRESS (If rural, give location) 438 Greenlow Rd.			
5. SEX M	6. RACE CAUC	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 6-1-10	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ware house man		10B. KIND OF BUSINESS OR INDUSTRY Cities Service oil Co		11. BIRTHPLACE (State or foreign country) BALTO MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME WATER WILLIAMS			14. MOTHER'S MAIDEN NAME BERTHA SMITH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS VIRGINIA B. WILLIAMS ADDRESS 438 Greenlow Rd.	
18. 384 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE UREMIA		CAUSE OF DEATH (A) Acute uremia DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PROBABLE PERITONITIS		(B) Probable peritonitis DUE TO		8 days	
		Acute Cholecystitis with Stone		21 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION May 4 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute cholecystitis		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1 1967 to May 21 1967 , that (I) (we) last saw the deceased alive on May 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Sullivan				23B. DATE SIGNED 5-21-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 1129 St Paul St Baltimore 2 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 25, 1967		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemt.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR P. E. E. Sullivan		25C. FUNERAL DIRECTOR STERLING FUNERAL ESTATE ADDRESS 736 Edmonds Av	

AND

Walter Williams

BERTHA

DAUGHTER

1924

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5011</u>	
BIRTH NO. <u>67 5011</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MILTON BROWN CRESWELL</u>		2. DATE AND HOUR OF DEATH <u>MAY 22, 1967</u> <u>1:45 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Harford Co.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BEK AIR</u> <u>62-32</u>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>739 ROLAND AVENUE</u>			
5. SEX <u>M</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>10/5/99</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO. TECH.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AUTOMOBILE</u>		11. BIRTHPLACE (State or foreign country) <u>JOPPA, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WILLIAM HARRY CRESWELL</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BROWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-03-2985</u>		17. INFORMANT (With) <u>838-4763</u> ADDRESS <u>CHART Mrs. Ruth W. Creswell</u> <u>739 Roland Ave.</u> <u>Bel Air, Md. 21014</u>	
18. <u>2000.01</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>PULMONARY EMBOLI</u> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ DUE TO			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>RETICULUM CELL SARCOMA</u> <u>J.B. Jerny</u>			
19A. DATE OF OPERATION <u>MAY 17, 1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RETICULUM CELL SARCOMA</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> 19 <u>67</u> to <u>5/22</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/22</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles E. Boring Jr.</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/22/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES E. BORING, JR.</u>		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 25, 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Fallston Methodist Ch. Cem.</u>	
24D. LOCATION <u>Fallston, Harford Co., Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 24 1967</u>			
25B. NAME OF REGISTRAR <u>Joseph William Foster</u>		25C. FUNERAL DIRECTOR <u>W. Broadway & Williams St.</u> <u>Bel Air, Maryland 21014</u>			

THE WHITE MEMORIAL HOSPITAL

CLAUDE E. THORNTON, JR.

Journal - 1902-1903
The White Memorial Hospital
The White Memorial Hospital
The White Memorial Hospital

1
M-216

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. 67 5012			
BIRTH NO. 67 5012				M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) ANDRIJA MASABERG				2. DATE AND HOUR PRONOUNCED DEAD May 21, 1967 7:40 A. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 Franklin Square Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 19-03 D. STREET ADDRESS (If rural, give location) 214 South Calhoun Street							
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH MAY 25-1892		9. AGE (in years last birthday) 74		10. CITIZENSHIP YUGOSLAVIA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER				10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL				11. BIRTHPLACE (State or foreign country) YUGOSLAVIA			
12. CITIZEN OF WHAT COUNTRY? YUGOSLAVIA				13. FATHER'S NAME JOHN MASABERG				14. MOTHER'S MAIDEN NAME MARY TROSEIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-32-6389				17. INFORMANT ROSE MASABERG 214 S. CALHOUN ST.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.04, 163 X Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of lung				INTERVAL BETWEEN ONSET AND DEATH							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED May 21, 1967			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				23B. DATE 5-24-67			
23C. NAME OF CEMETERY or CREMATORY LODGE PARK CEMETERY				23D. LOCATION (City, town, or county) (State) BALTIMORE-MARYLAND							
24A. DATE REC'D BY HEALTH DEPT. MAY 24 1967				24B. NAME OF REGISTRAR R. E. F. F. F.				24C. FUNERAL DIRECTOR WALTERS FUNERAL HOME			
24D. ADDRESS PRATT & STRICKER STS.											

WATERBURY ENGINE

WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE

WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE

WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE

WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE

WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE

WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE

WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE

WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE
WATERBURY ENGINE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67-09537 5013					Registered No. 67 5013					
BIRTH NO.					CERTIFICATE OF DEATH					
M.E. CASE NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) GANZERMILLER BABY BOY					5-21-67 2 45 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME HOSPITAL 100N. BROADWAY, BALTIMORE, MARYLAND 21231					A. STATE B. COUNTY MARYLAND BALTIMORE CITY					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 1-02					
					D. STREET ADDRESS (If rural, give location) 411 S. ELLWOOD AVE #24					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEW BORN		8. DATE OF BIRTH 5-20-67		9. AGE (In years last birthday) -		
								If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. - - 15 42		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) CHURCH HOME HOSPITAL BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME PETER GANZERMILLER					14. MOTHER'S MAIDEN NAME CAROLYN SCHELDING					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NO.		17. INFORMANT FATHER & MOTHER		ADDRESS SAME		
18. 760.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cordic arrest.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
					(A) POSSIBLE PULMONARY HYALINE MEMBRANE DUE TO PROBABLY C.N.S. mild petechial hemorrhage. PREMATURITY.			15 hr 42 minutes		
19A. DATE OF OPERATION NONE					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from 5-20-1967 to 5-21-1967, that (I) (we) lost saw the deceased alive on 2:30 PM → 2:45 PM 5-21-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Dr. Arnold Brenner								23B. DATE SIGNED 5-21-67		
23C. PHYSICIAN'S NAME (Type) DR. ARNOLD BRENNER					23D. ADDRESS M.D. 4726 Old Court Rd. Baltimore.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-22-1967		24C. NAME of CEMETERY or CREMATORY St. Stanislaus			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967			25B. NAME OF REGISTRAR R. E. Taylor			25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.				

2 2 5

RETURNED TO SENDER

LETTER

WILL 2 BROWN AVE #14

THOMAS H. BROWN, JR.
1011 BROWN, EAST 100th ST
CITY

2-10-47

WHITE NEW YORK

CHURCH HOUSE 100th ST
BROWN AVE 100th ST
A 24

CAROLYN BROWN

PETER BROWN

PETER BROWN

NY

NY

THE BROWN HOUSE
(BROWN AVE 100th ST)
PREPARED

Charles Brown

NY

NY

2-10-47
2-10-47

2-10-47

X

ALL OUR LOVE TO YOU

Charles Brown

OF BROWN BROWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5014				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5014	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) TRICARCHI-TRICARICA CALOGERO-CALOGERS				2. DATE AND HOUR OF DEATH 5-20-67 10.50 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND TRICARCHI				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO.			
5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed				8. DATE OF BIRTH 1-10-1875 9. AGE (In years last birthday) 92			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
11. BIRTHPLACE (State or foreign country) Sicily				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Giuseppe CALOGERO TRICARCHI				14. MOTHER'S MAIDEN NAME SANTINA -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-09-0328		17. INFORMANT MRS. SANDRA MESSNER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ① Pulmonary edema ② Congestive Heart Failure ③ Arteriosclerotic Cardiovascular Disease				19. CAUSE OF DEATH ① Pulmonary edema ② Congestive Heart Failure ③ Arteriosclerotic Cardiovascular Disease			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				21. INTERVAL BETWEEN ONSET AND DEATH 246			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-19 1967 to 5-20 1967 , that (I) (we) last saw the deceased alive on 5-20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francisco Paez M.D.				23B. DATE SIGNED 5-20-67		23C. PHYSICIAN'S NAME (Type) Francisco Paez M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 5-23-67		24C. NAME OF CEMETERY or CREMATORY MOST HOLY REDEEMER	
24D. LOCATION (City, town, or county) (State) BELAIR RD. BALTO., Md.				25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR'S ADDRESS 5444 BELAIR RD.				25D. NAME OF FUNERAL HOME St. John's Confraternity			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5015				Baltimore City Health Department		Registered No. 67 5015	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <i>JOHN HEIRICK</i>				2. DATE AND HOUR OF DEATH <i>5/22/67 1:40 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>37 Mercy</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>G.A.C.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie 52-00</i> D. STREET ADDRESS (If rural, give location) <i>209 Wilhelm Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2/1/18</i>	9. AGE (In years lost birthday) <i>49</i>	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Calvert Distillery</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Calvert Distillery</i>		11. BIRTHPLACE (State or foreign country) <i>Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unk</i>				14. MOTHER'S MAIDEN NAME <i>Unk</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>George Butz 3Park Dr Pasadena, Md</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH (A) <i>Acute Myocardial Infarction</i> <i>Several Hours</i> (B) <i>Previous Myocardial Infarctions</i> <i>4 yrs 3 yrs 3 wks</i> (C) <i>Arteriosclerotic Cardiovascular Disease</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5-22</i> 19 <i>67</i> to <i>5-22</i> 19 <i>67</i>, that (I) (we) last saw the deceased alive on <i>5-22-67</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.							
23A. SIGNATURE <i>Michael A. Ellis</i> M.D.				23B. DATE SIGNED <i>5-22-67</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>Michael A. Ellis</i>				23D. ADDRESS <i>Mercy Hospital Balto Md.</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/25/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Glen Haven Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Glen Burnie Md AA CO Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 24 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR <i>McCully F H 237 Patapsco Ave 21225</i>			

1/1 10/20/01

John Herick

Washed

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5016		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5016	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No. 67 5016	
1. NAME OF DECEASED (Type or Print) Frank J. Marshall		2. DATE AND HOUR OF DEATH 5/22/1967 4:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		A. STATE Maryland B. COUNTY Balto. Co.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN 7021-Carlbrook Ave 53-00			
		D. STREET ADDRESS (If rural, give location) Baltimore 24.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 7-15-1911	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MO	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Marshall			14. MOTHER'S MAIDEN NAME Mary Bayless		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-1727		17. INFORMANT HENRIETTA MARSHALL	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4-20-1 I (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH <1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4/21 1967 to 4/22 1967 that (we) last saw the deceased alive on 4/22 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE S. Spaulding M.D.				23B. DATE SIGNED 4/22/67	
23C. PHYSICIAN'S NAME (Type) STEPHEN W. SPAULDING				23D. ADDRESS JOHNS HOPKINS HOSPITAL,	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/25/67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN	
24D. LOCATION BALTO. MD.		24E. DATE REC'D BY HEALTH DEPT. MAY 24 1967			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR J. G. Connolly		25C. FUNERAL DIRECTOR 300 MACE	

APR 1975

Barb, old C street

Psychological Laboratory

1975

4/55

of

4/55

4/55

4/55

*

M.D. Gubler

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

Registered No.

1. NAME OF DECEASED
(Type or Print)

MICHAEL APPLEMAN

2. DATE AND HOUR PRONOUNCED DEAD

May 20, 1967

4:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore Co.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital (DOA)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

613 Beech Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER

8. DATE OF BIRTH

NOV 14 1964

9. AGE (In years last birthday)

2-1/2

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

CLARENCE J. APPLEMAN

14. MOTHER'S MAIDEN NAME

BETTY WARREN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

FATHER

ADDRESS

SAME

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Achondroplasia with Hydrocephalus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 20, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

5/23/67

23C. NAME of CEMETERY or CREMATORY

GARDENS OF FAITH

23D. LOCATION (City, town, or county)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

MAY 24 1967

24B. NAME OF REGISTRAR

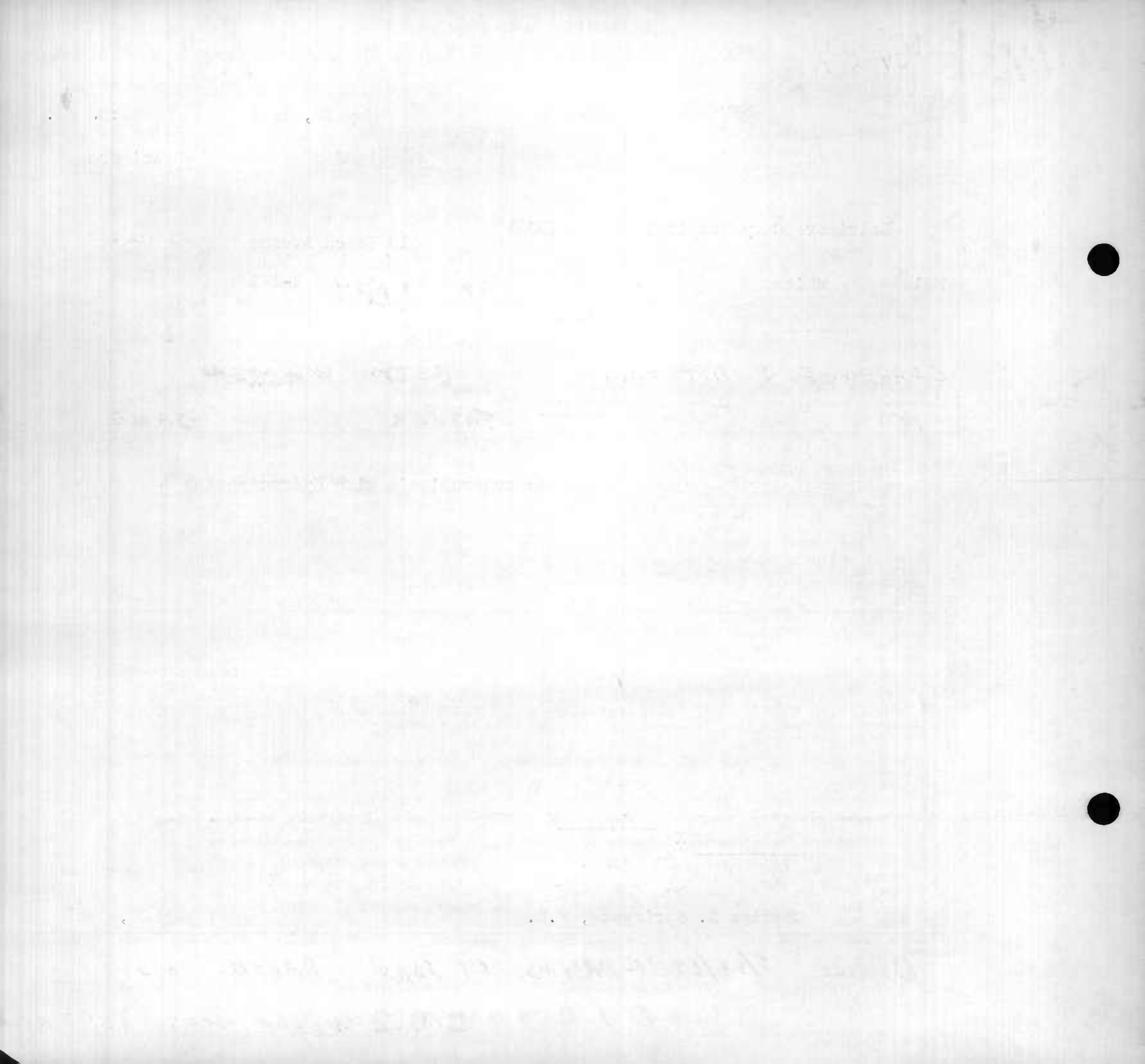
Charles E. Springate

24C. FUNERAL DIRECTOR

J. G. CAMPBELL SONS

ADDRESS

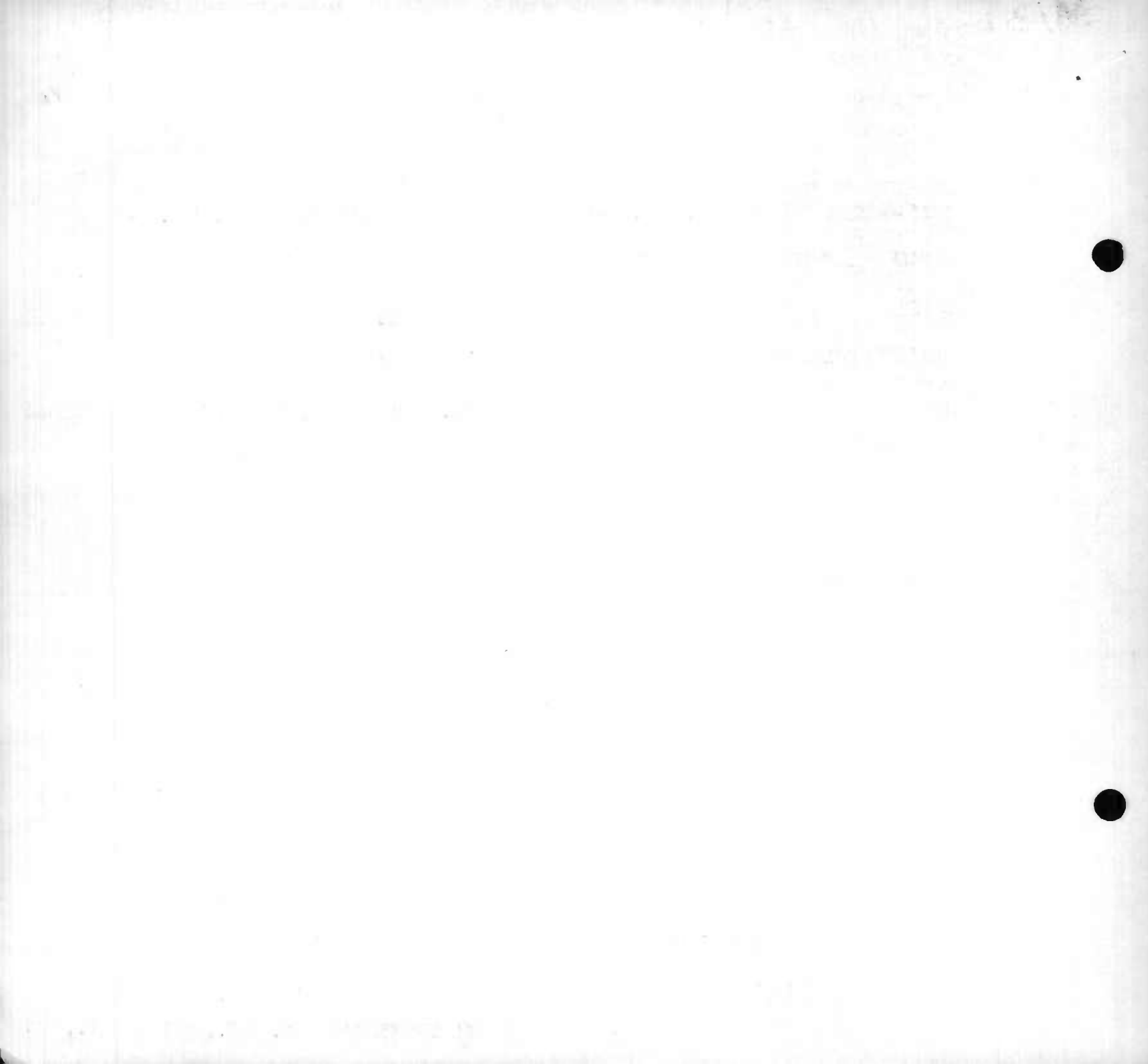
300 MA...



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5018	
BIRTH NO. 67 5018		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ESTHER GOLDBERG		2. DATE AND HOUR OF DEATH MAY 19, 1967 7:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND	
STATEMENT APARTMENTS		7022 PARK HEIGHTS AVENUE, APT. F-1		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
7022 PARK HEIGHTS AVENUE, APT. F-1		D. STREET ADDRESS (If rural, give location) 7022 PARK HEIGHTS AVENUE, APT. F-1		27-20	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 74	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUYER		10B. KIND OF BUSINESS OR INDUSTRY GUTMANS		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME BENJAMIN GOLDBERG		14. MOTHER'S MAIDEN NAME THERESA BLUMENSTEIN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MRS. ROSE RACHES, 7022 PARK HEIGHTS AVENUE	
18. 420.11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Coronary a.		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 55 to May 19 1967 , that (I) (we) last saw the deceased alive on May 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jerome Collier				23B. DATE SIGNED 5-20-67	
23C. PHYSICIAN'S NAME (Type) Jerome Collier				23D. ADDRESS 2217 SOUTH ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/21/67		24C. NAME of CEMETERY or CREMATORY CHIZUK AMINO (ARLINGTON)	
24D. LOCATION BALTIMORE, MARYLAND		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR SOI ROBINSON & BROS. INC., 6010 REIST., RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 5019	
BIRTH NO. 67 5019		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELAINE H. MICHELSON		2. DATE AND HOUR OF DEATH 5-20-67 12:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 C. H. & R. Home and Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 11-04 D. STREET ADDRESS (If rural, give location) MARYLAND			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 9-20-1914	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Met. Balto. Ass. For Mental Health		10B. KIND OF BUSINESS OR INDUSTRY SECRETARY		11. BIRTHPLACE (State or foreign country) N.Y.	
13. FATHER'S NAME Herman Michelson		14. MOTHER'S MAIDEN NAME Lillian Born.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-07-9837		17. INFORMANT ADDRESS MRS. LILLIAN MICHELSON, 3412 DOLFIELD AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) BRONCOGENIC CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH months			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-15-67 19 77 to 5-20 19 67 , that (I) (we) last saw the deceased alive on 5-20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edilia Mariano		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-20-67	
23C. PHYSICIAN'S NAME (Type) IDILIA MARIANO		23D. ADDRESS CHURCH HOME & HOSP. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/22/67		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR SOE LEDSON & BROS. INC. 6010 REISTERSTOWN			

100-100000

100-100000

100-100000

13

14

15

100-100000

14

100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5020	
BIRTH NO. 67 5020		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dawn Marie Hudson		2. DATE AND HOUR OF DEATH 5/22/67 1 2 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore University Hospital		A. STATE MD. B. COUNTY W. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1825 W. Pratt St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 3/8/65	9. AGE (In years last birthday) 2 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY child		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Larry Hudson		14. MOTHER'S MAIDEN NAME Brenda Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS oed chart	
18. 754.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Tetralogy of Fallot (B) DUE TO with nonworking Blalock-shunt (C) sepsis		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 1 week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/21/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED exploratory lap		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/13 1967 to 5/22 1967 , that (I) (we) last saw the deceased alive on 5/22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Martha Leffler		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/22/67	
23C. PHYSICIAN'S NAME (Type) MARTHA LEFFLER		23D. ADDRESS University Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/25/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cem.	
24D. LOCATION (City, town, or county) (State) Dorsey Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967			
25B. NAME OF REGISTRAR John E. Schuyler		25C. FUNERAL DIRECTOR John E. Schuyler		ADDRESS 901 Hollins St. 23 Md.	

Handwritten text at the top left, possibly a date or location.

Handwritten text in the middle right area, possibly a signature or initials.

Handwritten text in the lower middle area, possibly a page number or a small note.

Handwritten text at the bottom right, possibly a date or a reference number.

Handwritten text at the bottom left, possibly a signature or a long note.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

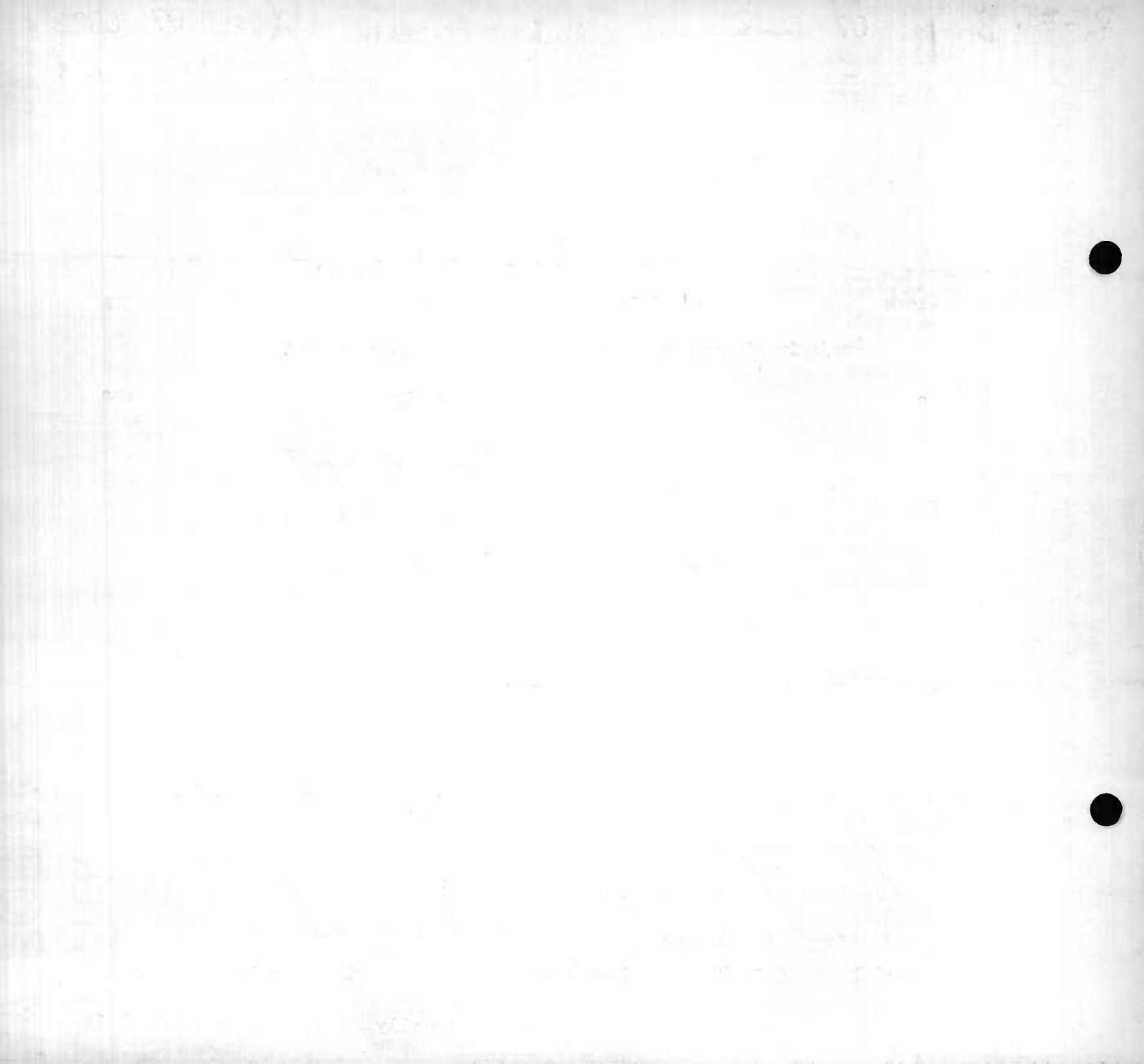
BIRTH NO. 67 5021				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5021	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Dorothy Lorraine Harms				2. DATE AND HOUR OF DEATH May 22, 1967 10:25 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Park Drive				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Va. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Fairfax D. STREET ADDRESS (If rural, give location) 11009 Delmar Court			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 3/14/35	9. AGE (In years last birthday) 32	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leo Shruhan				14. MOTHER'S MAIDEN NAME Ethel Douglas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma right breast ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH Years			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Apr. 10 1967 to May 22 1967 , that (I) (we) last saw the deceased alive on May 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael E. Pelczar M.D.						23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surg (R) M.D.				23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/26/67		24C. NAME OF CEMETERY or CREMATORY Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Fairfax, Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Michael E. Pelczar		25C. FUNERAL DIRECTOR ADDRESS Everly Funeral Home Fairfax, Va.			

Michael E. DeLozier

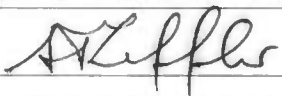
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5022				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5022	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ESTELLE RICHARDSON				2. DATE AND HOUR OF DEATH 5/22/67 3:45 p M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL OF MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY G. G. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 52-00 107 Walton Avenue			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 5/18/99	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY O'Neills		11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Richardson				14. MOTHER'S MAIDEN NAME Nettie Longest			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same	
18. 7-20-17-1538 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Atherosclerosis Old age				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ca, recto-sigmoid junction							
19A. DATE OF OPERATION 5/16/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca, colon, recto-sigmoid junction		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/9 19 67 to 5/22 19 67 , that (I) (we) last saw the deceased alive on 5/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Desiderio L. Hebron, Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/22/67	
23C. PHYSICIAN'S NAME (Type) DESIDERIO L. HEBRON				23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/26/67		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie AA CO Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Robert E. Carley		25C. FUNERAL DIRECTOR McCully F H		ADDRESS 237 Patapsco Ave 21225	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. X 67 5023				
BIRTH NO. Pr. 467 3023									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) JOSEPH LANSDALE YOUNG					2. DATE AND HOUR OF DEATH 5/17/67 1:50 AM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND B. COUNTY CHARLES Co.				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BRANDYWINE 38-00				
					D. STREET ADDRESS (If rural, give location)				
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER-MARRIED NEVER MARRIED		8. DATE OF BIRTH 9-24-60	9. AGE (In years lost birthday) 6	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince George Co. Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME LANSDALE DUCKY- Duckett					14. MOTHER'S MAIDEN NAME CORRINE YOUNG				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mother Brandywine. Maryland		ADDRESS		
18. 340.3 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) cerebral edema cerebral edema DUE TO		INTERVAL BETWEEN ONSET AND DEATH 29 hrs		
					(B) meningitis DUE TO		4 days - 3 weeks		
					(C) unknown organism DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5-15-67 19 to 5-17-67 19 that (I) (we) lost saw the deceased alive on 5-17-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE  S.T. LEFFLER					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/17/67		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 20/67		24C. NAME of CEMETERY or CREMATORY St. Peters Ch. Cem.		24D. LOCATION (City, town, or county) (State) Waldorf Chas. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR W. B. Adams		25C. FUNERAL DIRECTOR Mortell Adams		ADDRESS Aquasco, Maryland			

21

revised

PS. ~~revised~~ ~~revised~~

revised

revised

revised

revised

2

revised

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5024		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5024	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GRAZIOLO ROSE			2. DATE AND HOUR OF DEATH 5-22-67 11.40 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY H.S.A. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 6-05 D. STREET ADDRESS (If rural, give location) 1502 E. BALTIMORE ST. 21231		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH -	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNKNOWN Samuel Barshop			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	17. INFORMANT ADDRESS NORTH CHARLES GENERAL HOSPITAL		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive pulmonary embolism INTERVAL BETWEEN ONSET AND DEATH 2 months			(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Malnutrition (B) DUE TO			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8-19 1967 to 5-22 1967 , that (I) (we) last saw the deceased alive on 5-22-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chanthana Suddhimandala M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5-22-67	
23C. PHYSICIAN'S NAME (Type) Dr. SAMUEL S. RUBIN		23D. ADDRESS M.D. 201-203 PATAPSCO AVE. 21225 Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/24/67	24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Men's Cemetery		24D. LOCATION (City, town, or county) (State) Windsor Mill Rd. Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Jack Lewis, Inc.		25C. FUNERAL DIRECTOR ADDRESS 2100 Eutaw Place Balto. Md.	

10-1-63

251947262

10212 12 3400170 3 1021

NY

4-1-6

4-2-2

4-1-1

241794 242270 241947262

2-1-6

4-1

10-1-6

10-1-6

10-1-6

10-1-6

10-1-6 10-1-6 10-1-6

10-1-6 10-1-6

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5025

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JACOB

WEBER

Jr.

2. DATE AND HOUR PRONOUNCED DEAD

May 19, 1967

9:10 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Charles C.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Waldorf

D. STREET ADDRESS (If rural, give location)

Sub station Rd.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Nov. 13, 1909

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Hungary

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Weber sr.

14. MOTHER'S MAIDEN NAME

Elizabeth Brandt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

579-03-8367

17. INFORMANT

Elizabeth Hockenberry Waldorf, Md.

ADDRESS

18. E 904.9

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Craniocerebral Injury
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Unknown

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Unknown (probably fell)

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S NAME (Type)
Werner U. Spitz, M.D.CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/19/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

May 22, 1967

23C. NAME of CEMETERY or CREMATORY

Washington National

23D. LOCATION (City, town, or county)

Suitland, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 24 1967

24B. NAME OF REGISTRAR

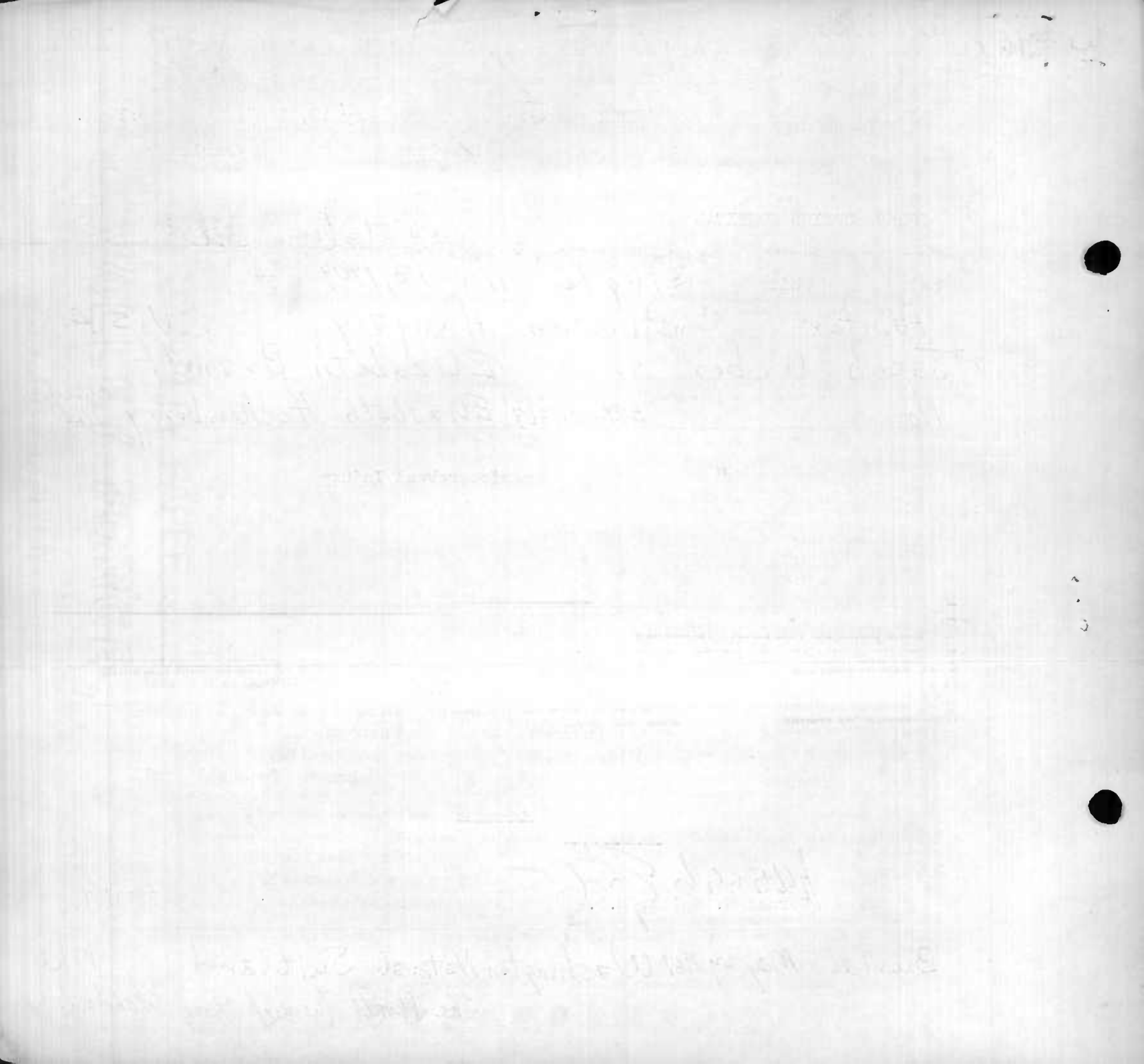
J. J. J. J.

24C. FUNERAL DIRECTOR

The Hunt Funeral Home

ADDRESS

Waldorf, Md.



L-200

67 5026

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5026

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PEARL LEWIS

2. DATE AND HOUR PRONOUNCED DEAD

5-22-67

12:12 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2734 W. FAIRMOUNT AVENUE - Amb. Crew #12

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

2734 W. Fairmount Avenue 21223

D. STREET ADDRESS (If rural, give location)

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 18, 1900

9. AGE (In years
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Darlington S.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Irvine Muldrow

14. MOTHER'S MAIDEN NAME

Jane Muldrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Samuel Lewis 2734 Fairmount Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-26-67

23C. NAME of CEMETERY or CREMATORY

Carver Mem. Park

23D. LOCATION

Laurel

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 24 1967

24B. NAME OF REGISTRAR

John G. Fulmer

24C. FUNERAL DIRECTOR

Morton & Dyett F.H.

ADDRESS

1701 Laurens St.

WALLEY

WALLEY

WALLEY

1
m-246

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5027		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 67 5027	
1. NAME OF DECEASED (Type or Print) ABRAHAM MC CLEARY		2. DATE AND HOUR PRONOUNCED DEAD May 20, 1967 6:55 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital (DOA)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 867 W. Franklin Street	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH
		9. AGE (In years last birthday) 40	If Under 1 Yr, If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Sumpter South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ben McCleary	
14. MOTHER'S MAIDEN NAME Rena Chestnut		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 220-24-8063		17. INFORMANT ADDRESS Mrs. Helen Peoples 1734 Ashburton St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED May 21, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5-25-67	
23C. NAME OF CEMETERY or CREMATORY MT. Auburn		23D. LOCATION (City, town, or county) (State) Ba Ho, Md.	
24A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		24B. NAME OF REGISTRAR Robert E. Taylor	
24C. FUNERAL DIRECTOR Robert E. Taylor		ADDRESS 1701 Laurens St.	



M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

IRVIN CROMWELL

2. DATE AND HOUR PRONOUNCED DEAD

May 20, 1967 11:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46
99 Lutheran Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1826 Mosher Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Student

8. DATE OF BIRTH

10-8-1950

9. AGE (In years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Cromwell

14. MOTHER'S MAIDEN NAME

Charlotte E. Fraizer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Charlotte Fraizer 1826 Mosher St.

18.

E981 X 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot wound of thorax
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

alley

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

rear of 1000 Block of
Monroe Street alley

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

5-20-67

?

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot by unknown assailant

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 21, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-25-67

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l

23D. LOCATION

Balto.

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 24 1967

24B. NAME OF REGISTRAR

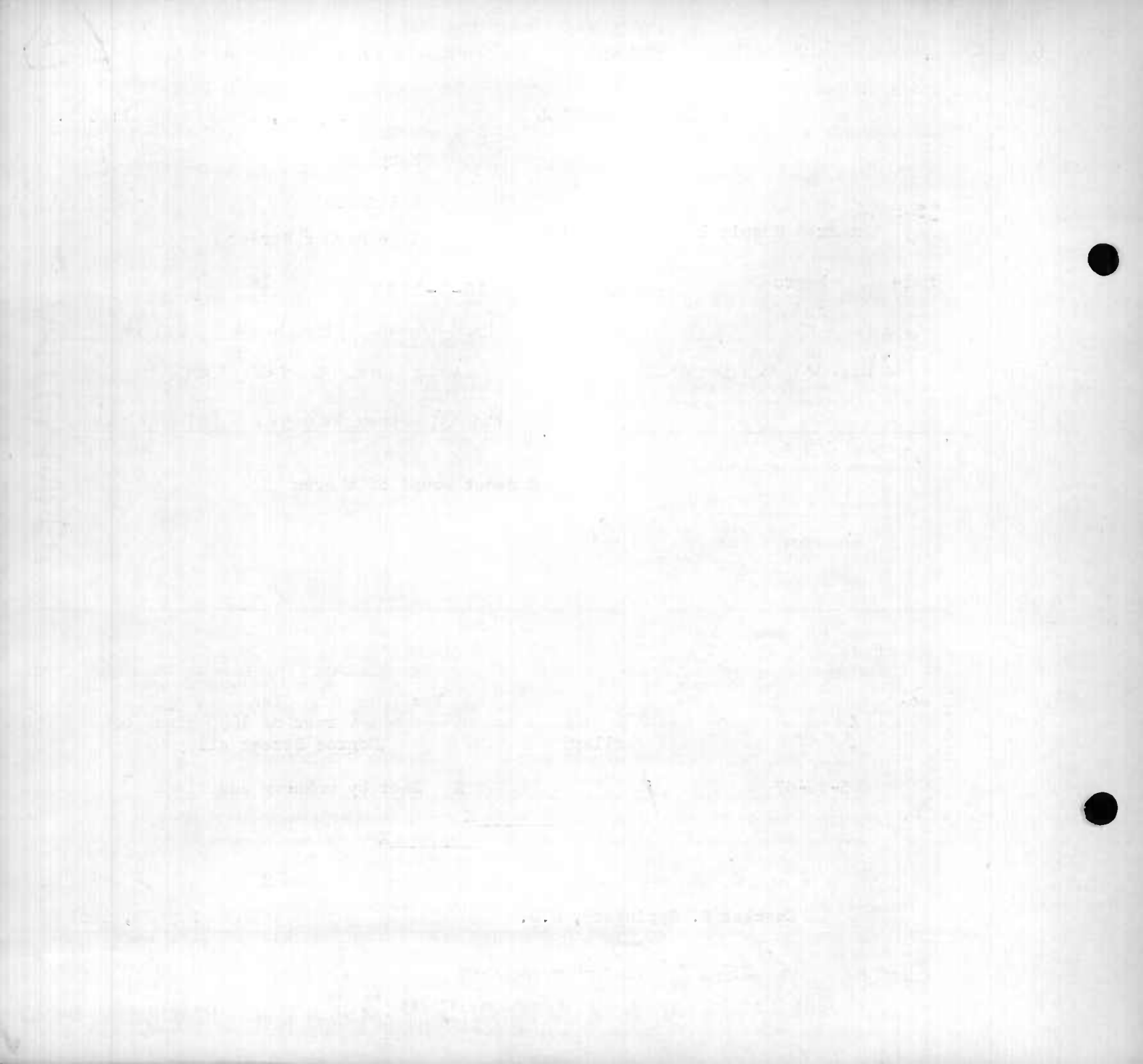
Robert S. Johnson

24C. FUNERAL DIRECTOR

Yorkton & Dyck F.H.

ADDRESS

1701 Laurens St.



T-400

67 5029

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5029

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Joseph E. Tilley, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

May 22, 1967

3:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2515 N. ROSEDALE AVENUE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2515 N. Rosedale Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

3/26/24

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Harbor Tunnel Dist.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph L. Tilley Sr.

14. MOTHER'S MAIDEN NAME

Mary Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

16. SOCIAL
SECURITY NO.

218-14-7098

17. INFORMANT

Mr. Melvin Tilley 1919 Riggs Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2515 N. Rosedale Avenue

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) May 22 '67

9:00 A.M. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot in chest

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/23/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/26/67

23C. NAME of CEMETERY or CREMATORY

BALTO NAT'L Cem.

23D. LOCATION

(City, town, or county)

(State)

BALTO, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 24 1967

24B. NAME OF REGISTRAR

R. E. Tilley

24C. FUNERAL DIRECTOR

Horton & Dyett

ADDRESS

1701 Square ~ S
Fun. Home, Inc.

WALLLEY FORGIE

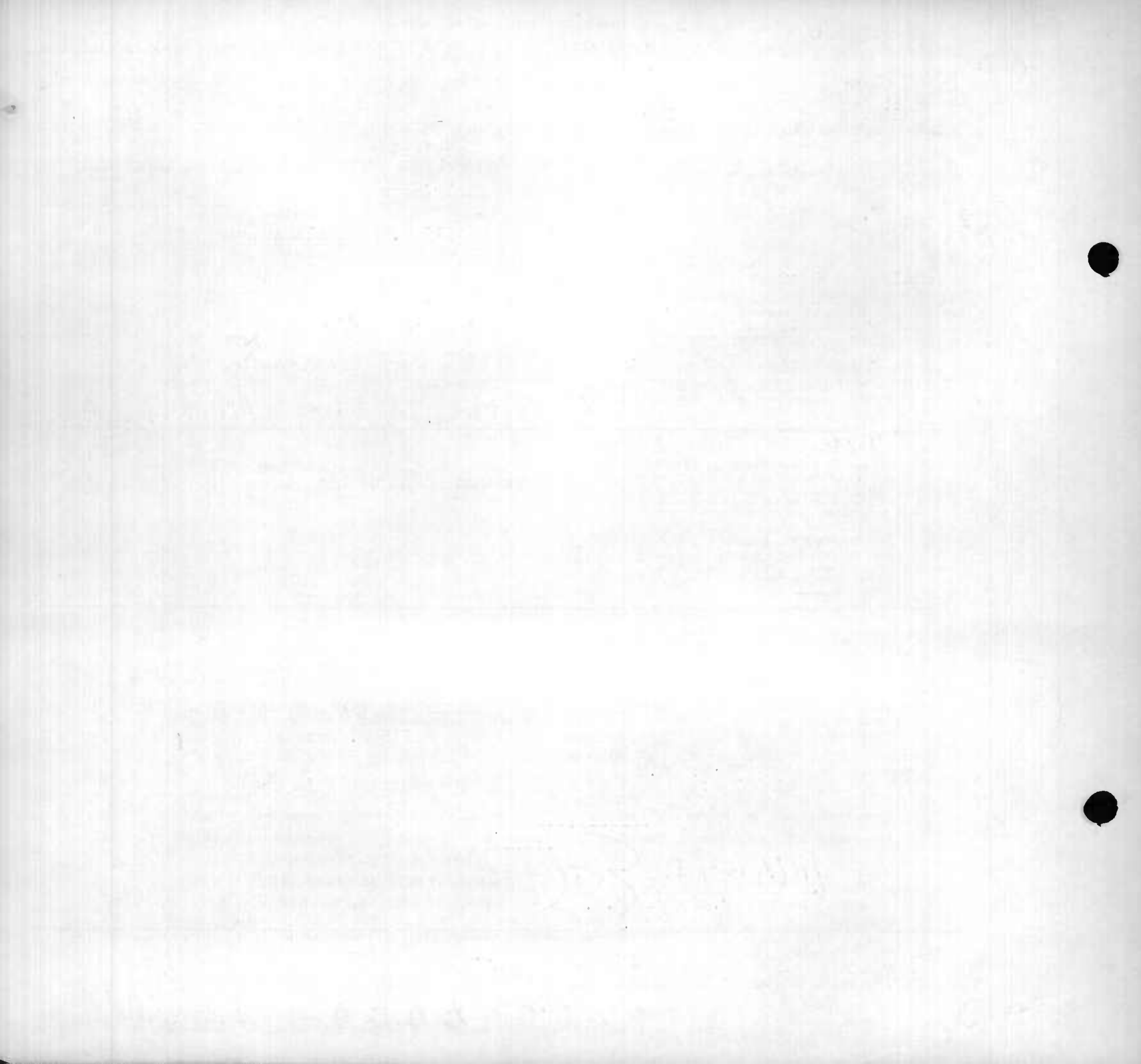
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) Mildred Tilley		2. DATE AND HOUR PRONOUNCED DEAD May 22, 1967 3:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2515 N. ROSEDALE AVENUE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 15-37 D. STREET ADDRESS (If rural, give location) 2515 N. Rosedale Avenue	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 4/29/21
9. AGE (In years last birthday) 46		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) BALTO. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm O. White		14. MOTHER'S MAIDEN NAME CORA E. GARRETT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Melvin Tilley		ADDRESS 1919 Riggs Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E976X I Gunshot wound of head DUE TO (A) _____ DUE TO (B) _____ DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION 5/20/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2515 N. Rosedale Avenue 15-37		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 5 22 '67 3:40 P.M.	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? shot self in head	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/23/67			
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 5/20/67	
23C. NAME of CEMETERY or CREMATORY BALTO. NAT L		23D. LOCATION (City, town, or county) (State) BALTO. Md.	
24A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		24B. NAME OF REGISTRAR Robert E. Spitz	
24C. FUNERAL DIRECTOR MORTON DYETT		ADDRESS 1701 LAURENS FUN. HOME INC	



FUNERAL DIRECTOR: IMPORTANT

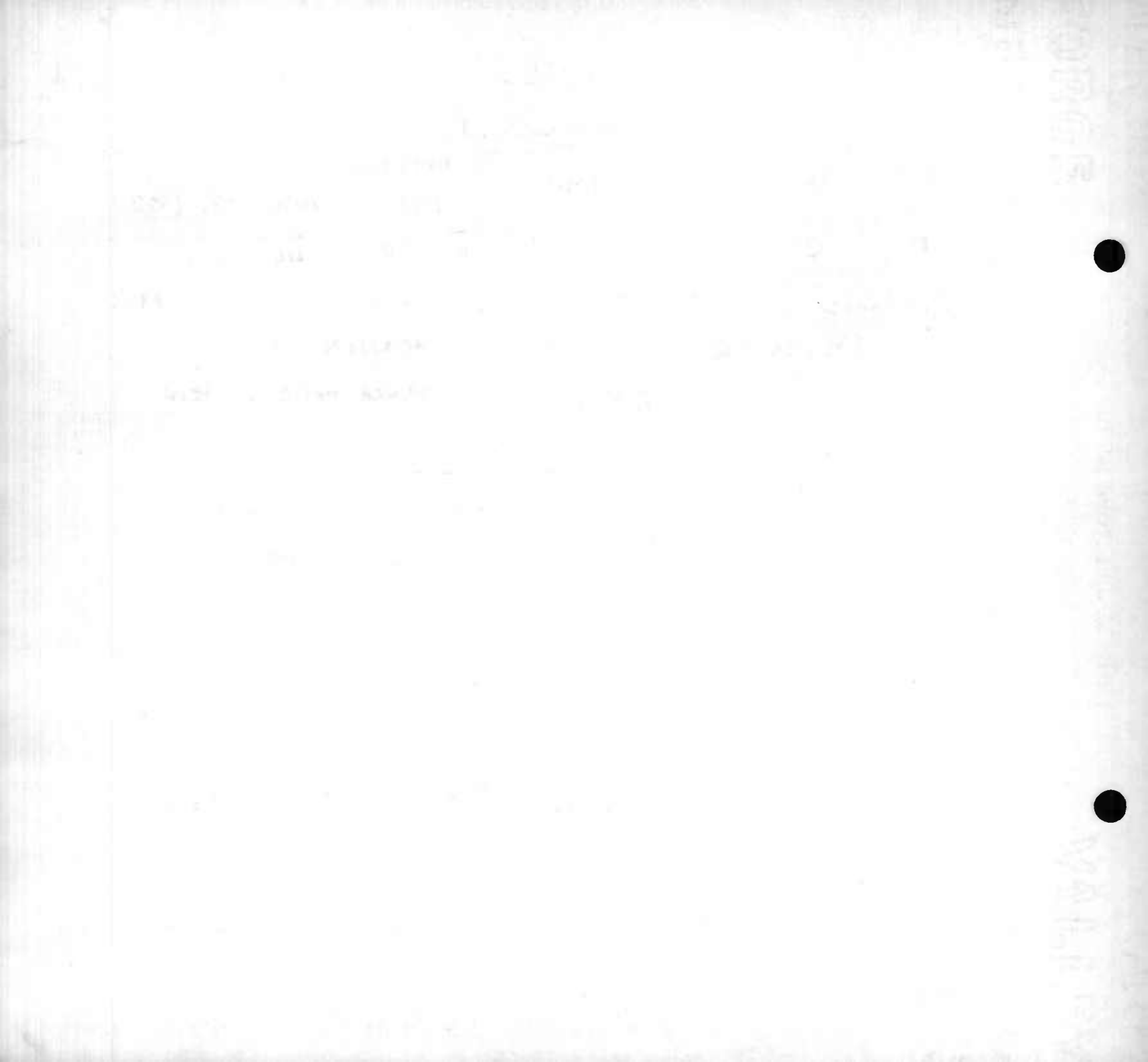
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5031	
BIRTH NO. 67 5031		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CINTHA SAMANTHA WARNER		2. DATE AND HOUR OF DEATH MAY 22 - 1967 1.05 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 14-03			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21217			
2020 DRUIDHILL AVE Apt 3		D. STREET ADDRESS (If rural, give location) 2020 DRUIDHILL AVE Apt 3			
5. SEX FEMALE	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH MARCH 16 1907	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY Put Family		11. BIRTHPLACE (State or foreign country) HARFORD Co MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ISAAC C. WILLIAMS		14. MOTHER'S MAIDEN NAME NANCY P. PITS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 245-32-1410		17. INFORMANT ADDRESS Mc. Tildon - WASHINGTON D.C.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) C-V-A. - Rt. Heart plegia.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/9 19 66 to 5/22 19 67 , that (I) (was) lost saw the deceased alive on 5/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Was) (did) view the body after death.					
23A. SIGNATURE J. Preston Grant M.D.				23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) J. Preston Grant,		23D. ADDRESS M.D. 601 N. Carrollton Ave. Balto., Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE Apr 67	24C. NAME of CEMETERY or CREMATORY Grave Church	24D. LOCATION (City, town, or county) (State) Aberdeen-HARFORD Co. MD		
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS 635 N. Gilmore St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5032				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5032	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROBINSON, MR WILLIAM				2. DATE AND HOUR OF DEATH 5.15. 1967 8.30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME + HOSP.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 6-05 D. STREET ADDRESS (If rural, give location) 1734 E. BALTO. ST. (02)			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 11.1.20	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		10B. KIND OF BUSINESS OR INDUSTRY Const.		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? AMR.	
13. FATHER'S NAME SYLVESTER ROBINSON				14. MOTHER'S MAIDEN NAME HENSON Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-18-7865		17. INFORMANT CHURCH HOME + HOSP.		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO Coma & Anoxia (B) DUE TO Hypovolemia (G.I. Bleeding) (C) Stomach Ulcer - Stomach		INTERVAL BETWEEN ONSET AND DEATH ? ?	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No))		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-6 1967 to 5-15 1967, that (I) (we) last saw the deceased alive on 5-15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Roderio M. Lim M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Roderio M. Lim M.D.	
23D. ADDRESS Church Home + Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-19-67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Balto. Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR M. J. E. F. J. M. D.		25C. FUNERAL DIRECTOR K. M. B. Oden		ADDRESS 1303 Resettman	



F-425

BALTIMORE CITY HEALTH DEPARTMENT				67 5033	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
BIRTH NO. 67 5033				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) JAMES FAULKNER Jr.				2. DATE AND HOUR PRONOUNCED DEAD 5-12-67 3:50 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HARBOR - 3100 BLOCK HANOVER STREET				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 625 Round View Road	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married	8. DATE OF BIRTH 8-28-53	9. AGE (In years lost birthday) 14	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Monroe Faulkner Sr.			14. MOTHER'S MAIDEN NAME Kathleen L. Robinson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. James M. Faulkner Sr. 625 Round View Rd.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Drowning					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HARBOR		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3100 Block Hanover Street North End of 500 ft. span	
21D. TIME OF INJURY (APPROX.) 5 12 '67 PM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell from make-shift raft into water.	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D. NAME (Type) WERNER U. SPITZ, M.D.					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED 5-13-67					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5-18-67		23C. NAME OF CEMETERY or CREMATORY Balto. National	
23D. LOCATION (City, town, or county) (State) Baltimore Md.		24A. DATE REC'D BY HEALTH DEPT. MAY 24 1967			
24B. NAME OF REGISTRAR R. G. E. Taylor		24C. FUNERAL DIRECTOR R. G. E. Taylor			
24D. ADDRESS BALTO. MD.					

N990X

— 33 —

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5034				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5034	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) MARY V. Buck						May 20, 1967 8:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
Church Home + Hospital.				500 Wilton Rd., Towson			
355				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore, Maryland Balt Co.	
				D. STREET ADDRESS (If rural, give location)		500 Wilton Rd. 53-00	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
F	W	MARRIED	April 2, 1916	51	house wife	Baltimore, Md.	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
Joseph Brzezinski			Fritch				
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
no			215-03-4183		Mr. M. Buck 500 Wilton Rd., Towson Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) Carcinoma large bowel		20 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Ovarian and generalized			
				(C) abdominal metastasis			
				Carcinomatosis			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
Sept. 1965		exploratory laparotomy for abdominal mass		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Feb 23 1967 to May 20 1967, that (I) (we) lost saw the deceased alive on May 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 8:20 P.M.							
23A. SIGNATURE				23B. DATE SIGNED			
L. Rafael Miranda M.D.				5/20/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		5/24/67		HOLY ROSARY		BALTIMORE, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 24 1967		George A Weber		George A Weber		7055 Ann r	

1902

1000

1000

1000

1000

1000

1000

1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5035		CERTIFICATE OF DEATH		Registered No. 67 5035	
1. NAME OF DECEASED (Type or Print) George (Wojciech) F. Sroka						2. DATE AND HOUR OF DEATH May 23, 1967 7:10 a. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3206 Hudson Street						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3206 Hudson Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 26, 1897	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Cemetery Caretaker		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Blaze Sroka			14. MOTHER'S MAIDEN NAME Eva						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-30-9918		17. INFORMANT ADDRESS Mrs. Cecelia Sroka - 3206 Hudson St. #21224				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinomatosis - granulosa Carcinoma of Colon						CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 10/11/66 19 to 5/23 19 67 , that (I) (we) last saw the deceased alive on 5/19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Edward A. Flanigan Jr. M.D.						23B. DATE SIGNED 5/23/67			
23C. PHYSICIAN'S NAME (Type) Edward A. Flanigan Jr. M.D.						23D. ADDRESS 3501 Faint Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/27/67		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR George A. Weber		25C. FUNERAL DIRECTOR ADDRESS George A. Weber - 705 S. Ann Street #21231					

Black & white

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5036				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 5036	
1. NAME OF DECEASED (Type or Print) <i>Heil, Catherine</i>				2. DATE AND HOUR OF DEATH <i>5/24/67 4:40 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>91 Montebello State Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-34</i> D. STREET ADDRESS (If rural, give location) <i>5301 Remond Ave.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>9 Feb 1891</i>		9. AGE (In years last birthday) <i>76</i>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Schneider</i>				14. MOTHER'S MAIDEN NAME <i>Gertrude ?</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>214-03-2458</i>		17. INFORMANT ADDRESS <i>Werner Heil 24 McCormick Ave</i>			
18. <i>450.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Cardiac decompensation</i> DUE TO (B) <i>arteriosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Sanility</i>									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <i>this hospital</i> attended the deceased from <i>10/24 1966</i> to <i>5/24 1967</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>5/24 1967</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> (did not) view the body after death.									
23A. SIGNATURE <i>Robert W. Ireland</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/24/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>Robert W. Ireland</i>				23D. ADDRESS <i>Montebello State Hosp</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/27/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 24 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Buck, Inc.</i>		ADDRESS <i>Balto. Md. 21214</i>			

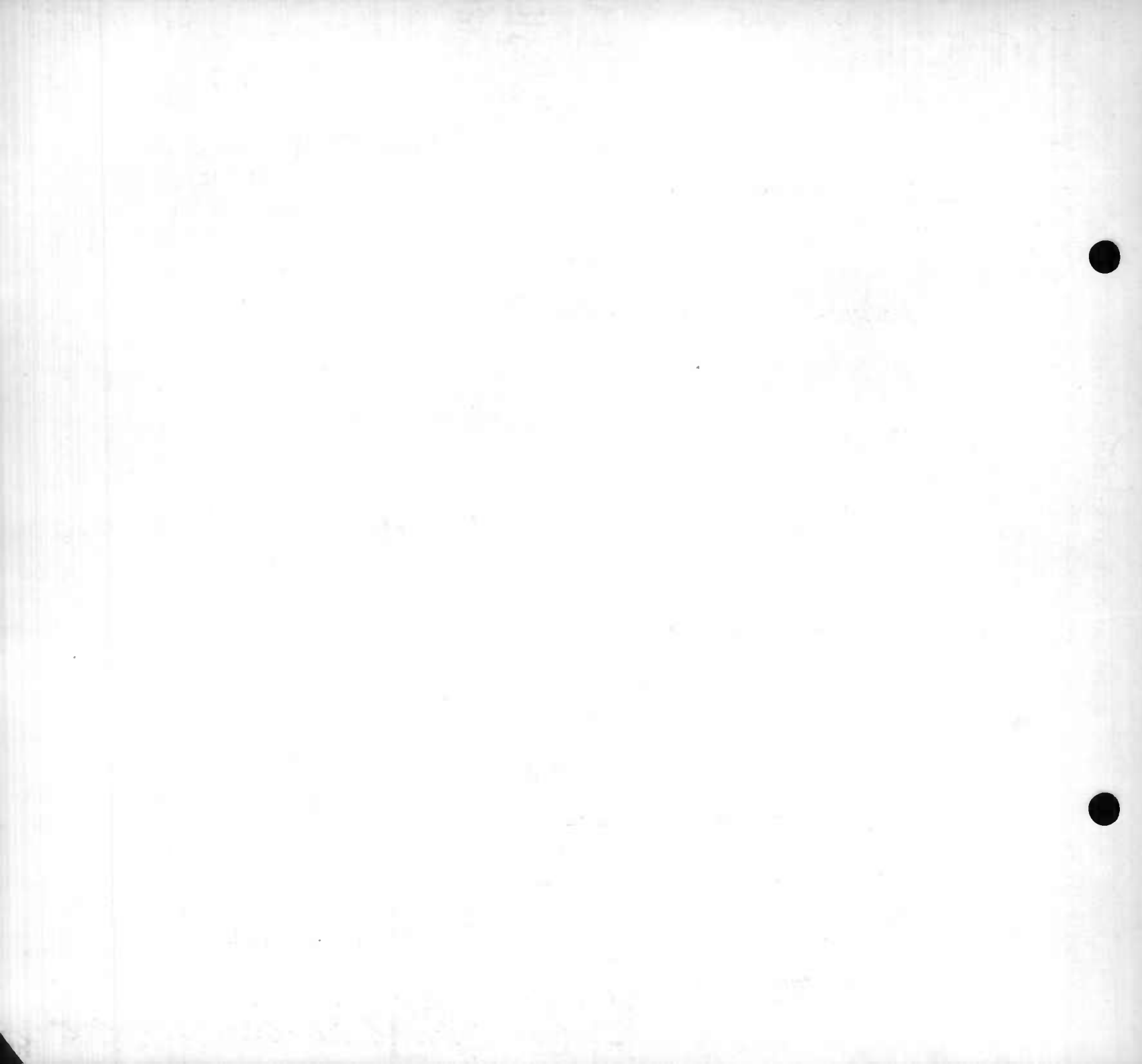
Montebello State Hosp

Robert W. Ireland

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
67 5037					67 5037					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
YORK EGGLESTON					5/23/67 10:45 AM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL					A. STATE MD MARYLAND					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					BALTIMORE					
					D. STREET ADDRESS (If rural, give location)					
					1216 N. Bay St					
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 11-28-06	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Retired Laborer Bethlehem Steel			Mechanics Wv.			USA				
13. FATHER'S NAME YORK EGGLESTON SR.					14. MOTHER'S MAIDEN NAME TEMPLE WALTON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO.		17. INFORMANT Ophelia Eggleston				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 331X I			CAUSE OF DEATH (A) DUE TO CVA				INTERVAL BETWEEN ONSET AND DEATH 4 weeks			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO pneumonia				5 days			
(C)										
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 4/29 19 67 to 5/23 19 67, that (I) (we) last saw the deceased alive on 5-23-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Robb E. Moses					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/23/67			
23C. PHYSICIAN'S NAME (Type) Robb E. Moses					23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE May 25/67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park			24D. LOCATION (City, town, or county) (State) Arbutus Mem. Park -		
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967			25B. NAME OF REGISTRAR R. E. Eggleston			25C. FUNERAL DIRECTOR J. E. Eggleston			ADDRESS 1129 N. Calhoun	



W-452

67

5038

BALTIMORE CITY HEALTH DEPARTMENT

67

5038

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DEMATRIS WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

5-21-67

7:05 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2640 Miles Avenue 21211

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 9, 1914

9. AGE (In years
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Patterson

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Mr. Julian V. Williams 2640 Miles Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Spontaneous intracerebral hemorrhage

XXXX

(Pons)

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-22-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/26/67

23C. NAME of CEMETERY or CREMATORY

Emory Patterson Square

23D. LOCATION (City, town, or county)

Buchanan, Virginia

(State)

24A. DATE REC'D BY HEALTH DEPT.

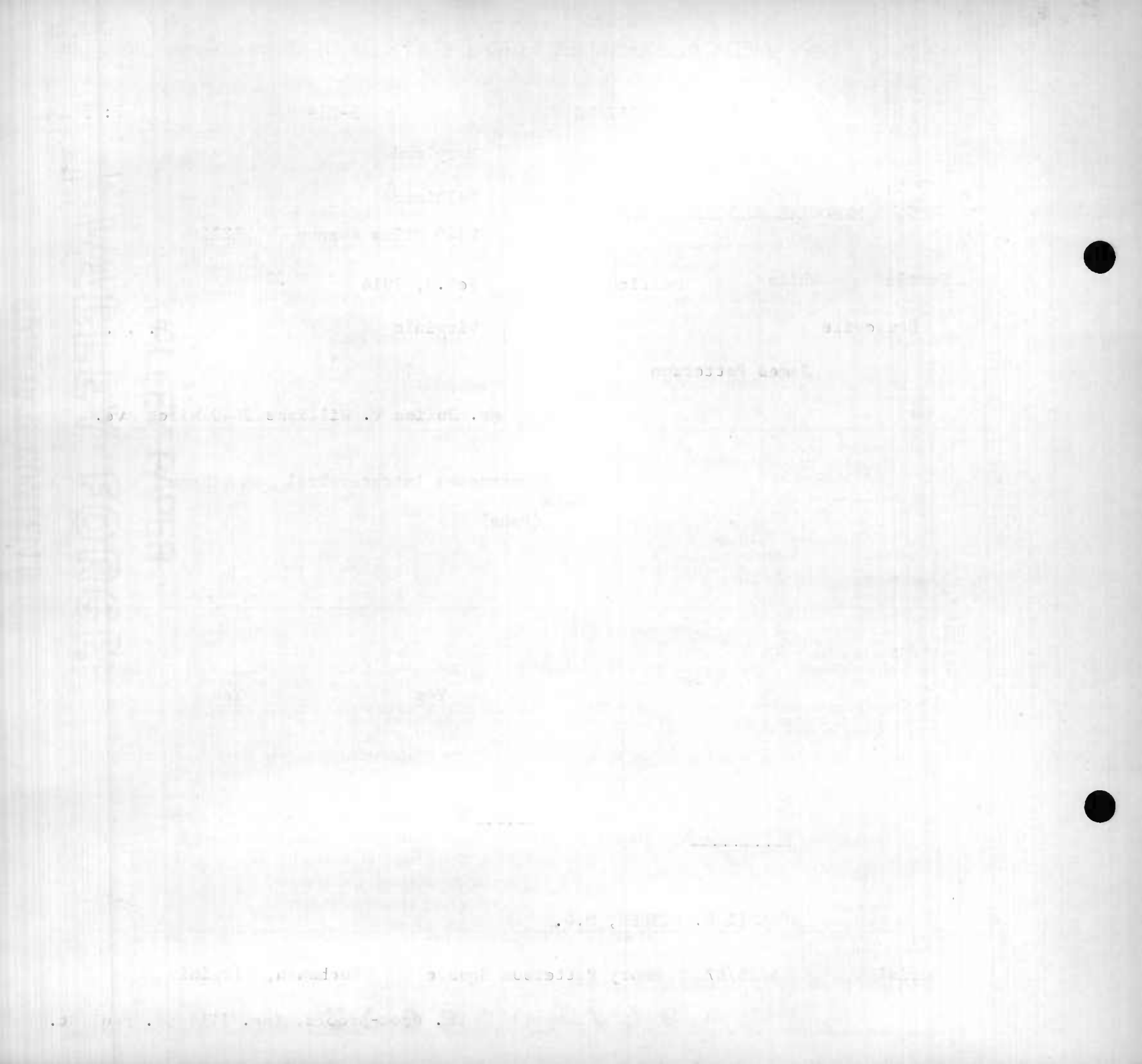
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

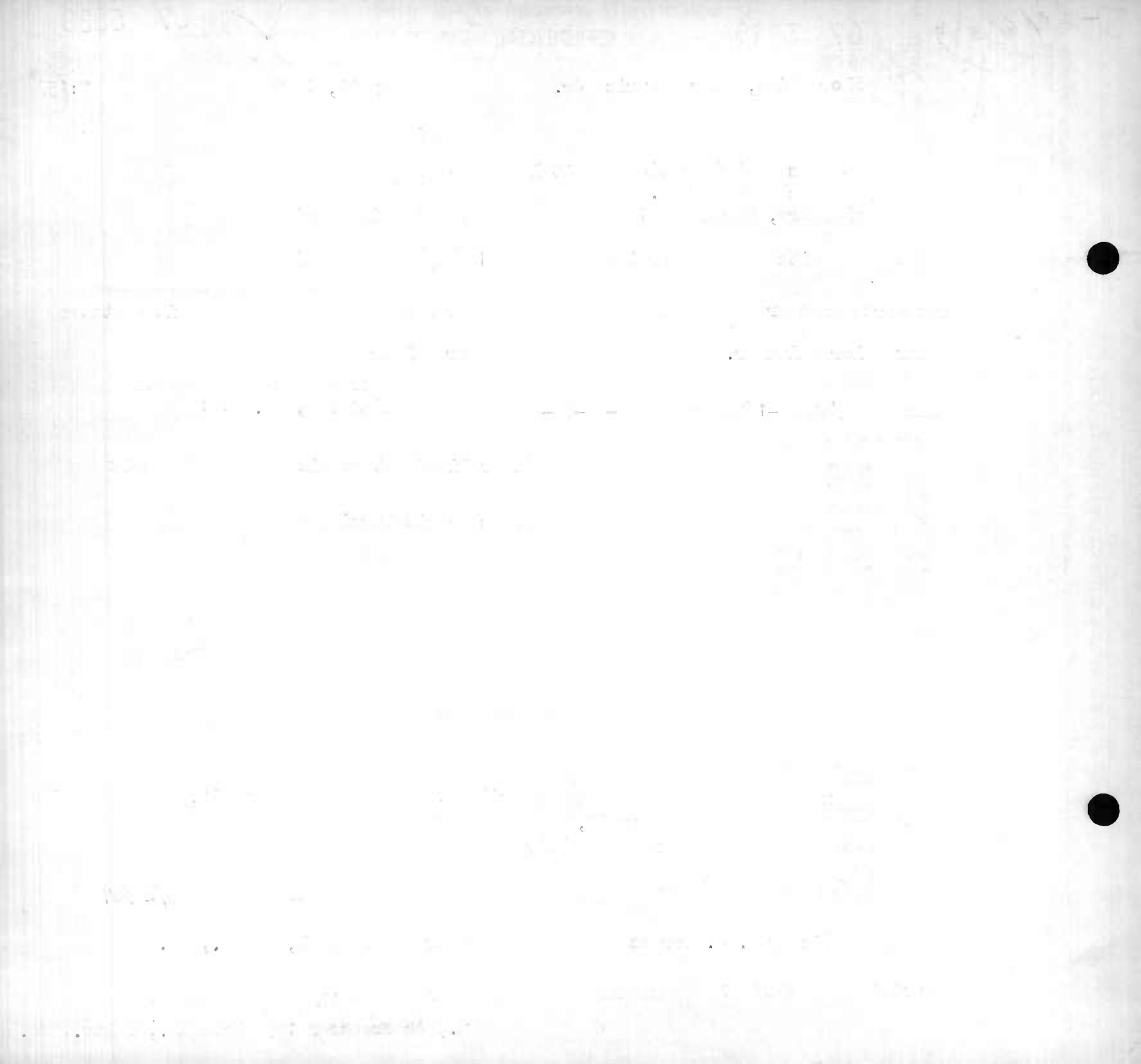
MAY 24 1967

Wm. Cooke-Brooks, Inc. 1217 St. Paul St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5039	
BIRTH NO. 67 5039				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Florentine, Henry Maurice Jr.				May 22, 1967 7:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				A. STATE Maryland B. COUNTY Baltimore	
5. SEX Male				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Timonium	
6. RACE White				D. STREET ADDRESS (If rural, give location) 55 Timonium Road	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married				B. DATE OF BIRTH 12/19/20	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Zone Parts Manager				9. AGE (In years last birthday) 46	
10B. KIND OF BUSINESS OR INDUSTRY Unknown				11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Florentine Sr.				12. CITIZEN OF WHAT COUNTRY? United States	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/24/42-1/20/45				16. SOCIAL SECURITY NO. 220-05-75-48	
17. INFORMANT Veterans Hospital Records Baltimore, Md. 21218				ADDRESS	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalized Metastatic Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bronchogenic Carcinoma II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH Days	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 21, 1967 to May 22, 1967, that (I) (we) lost saw the deceased alive on May 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Victor V. J. Borges M.D.				23B. DATE SIGNED 5/22/67	
23C. PHYSICIAN'S NAME (Type) Victor V. J. Borges M.D.				23D. ADDRESS Veterans Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/26/67		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Cemetery	
24D. LOCATION Cockeysville, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAY 24 1967		24F. NAME OF REGISTRAR WM. Cook Brooks	
24G. FUNERAL DIRECTOR TOWSON		24H. ADDRESS 1050 York RD., Balto., Md.		24I. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5040				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5040	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>NEVA SCHOKK</i>				2. DATE AND HOUR OF DEATH <i>MAY 23, 1967 8:20 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			
				D. STREET ADDRESS (If rural, give location) <i>2927 N. Charles St.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>07-14-87</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John G. Schokk</i>				14. MOTHER'S MAIDEN NAME <i>Betty Wagner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>MISS MARGARET N. SCHOKK (SISTER)</i>		ADDRESS <i>SAME</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Thrombosis</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO		(B) DUE TO	
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>MAY 22, 1967</i> to <i>MAY 23, 1967</i> , that (I) (we) last saw the deceased alive on <i>MAY 23, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>James W. Carty, Jr.</i> M.D.				23B. DATE SIGNED <i>5/23/67</i>		23C. PHYSICIAN'S NAME (Type) <i>JAMES W. CARTY, JR.</i> M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Entombment</i>		24B. DATE <i>5/25/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid ridge Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 24 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks, Inc.</i>		ADDRESS <i>1217 St. Paul St.</i>	

1900
March 1st

John Howard Wright
5945 N. Clark St.

Chicago, Ill.

Dear Sir:

John C. Edgar

is

with papers
and money in room 200

Chicago, Illinois

Yours

W

John C. Edgar
John C. Edgar

1900

1900

1
R-252

67 5041		BALTIMORE CITY HEALTH DEPARTMENT		67 5041	
BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		CARL E. RUSHING		2. DATE AND HOUR PRONOUNCED DEAD May 20, 1967 6:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE North Carolina	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Monroe	
43 South Baltimore General Hospital		D. STREET ADDRESS (If rural, give location)		Rt. #8, Box 199-A	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH March 30, 1936	9. AGE (In years last birthday) 31	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10B. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) Lancaster, South Carolina	
13. FATHER'S NAME Brady C. Rushing		14. MOTHER'S MAIDEN NAME Nettie L. Craig		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 1/1956 -- 5/20/67		16. SOCIAL SECURITY NO. 242-48-3912		17. INFORMANT U.S. Navy Records, USS Duvall County	
18. E 816.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple traumatic injuries		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Pontiac Avenue at 5th Avenue 25-04	
21D. TIME OF INJURY (APPROX.) 5-20-67 12:15 P. M.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver in auto-auto collision	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 21, 1967	
ACTUAL SIGNATURE Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE May 24, 1967		23C. NAME of CEMETERY or CREMATORY LAKELAND MEMORIAL PARK Cem.	
24A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		24B. NAME OF REGISTRAR 192.65 2. Baltimore		24C. FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland	
23D. LOCATION (City, town, or county) (State) Union County, North Carolina		24D. ADDRESS			

11869.2

ALBANY, N.Y.

1871

March 1, 1871

Dear Sir,

I have the honor

to acknowledge the receipt

of your letter of the 28th

inst.

in relation to the

subject of the

proposed

amendment to the

constitution of the

State of New York.

I am very glad to hear

that you are in favor of

the proposed change.

I am, Sir, very respectfully,

Your obedient servant,

Wm. H. Hunt

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5042	
BIRTH NO. 67 5042		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William MacDonald		2. DATE AND HOUR OF DEATH 19 May 1967, 8:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Prince George's C. CITY OR TOWN (If outside city limits, write RURAL and give township) Montgomery Laurel D. STREET ADDRESS (If rural, give location) 419 Montgomery Ave 66-00			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3-2-04	9. AGE (in years last birthday) 63	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) re'l		10B. KIND OF BUSINESS OR INDUSTRY Lawyer		11. BIRTHPLACE (State or foreign country) Michigan	
13. FATHER'S NAME Donald MacDonald		14. MOTHER'S MAIDEN NAME Maria Roberts			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No - - - -		16. SOCIAL SECURITY NO. 579-52-2849		17. INFORMANT Mrs. Martha MacDonald, Same as #4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Hepatic coma haennec's cirrhosis (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/17 & 5/19/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED upper airway obstr.; pyloric obstr.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (we) (this hospital) attended the deceased from 5/15 19 67 to 5/19 19 67, that (we) last saw the deceased alive on 5/19 19 67 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23. SIGNATURE Susan L. Howard				23B. DATE SIGNED 5/19/67	
23C. PHYSICIAN'S NAME (Type) SUSAN L. HOWARD		23D. ADDRESS M.D. University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE May 23, 1967		24C. NAME OF CEMETERY or CREMATORY CEDAR HILL CEMETERY	
				24D. LOCATION (City, town, or county) (State) Suitland, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR R. E. E. E.		25C. FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5043				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5043	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Leslie Hartwell Parmelee		May 17, 1967 3: 50 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
US Public Health Service Hospital				Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
3100 Wyman Park Drive				Laurel		66-00	
D. STREET ADDRESS (If rural, give location)				9003 Contee Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
F	W	Married	9/22/41	25			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Analyst		U.S.GOV'T		Mass.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Lester Hartwell				Mary Fenton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		032-30-6774		Records- US PHS Hospital, Balto, Md.			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I				Months			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Teratocarcinoma, ovary			
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				yes		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Dec. 15 1966 to May 17 1967, that (I) (we) last saw the deceased alive on May 17 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Michael E. Pelczar M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						5/18/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Michael E. Pelczar, SA Surgeon (R)				US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		May 20, 1967		St. Mary's Cemetery		Lynn, Mass	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 24 1967		R. E. E. E. E.		Harold S. Wade		Laurel, Maryland	

Michael E. DeLoe

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

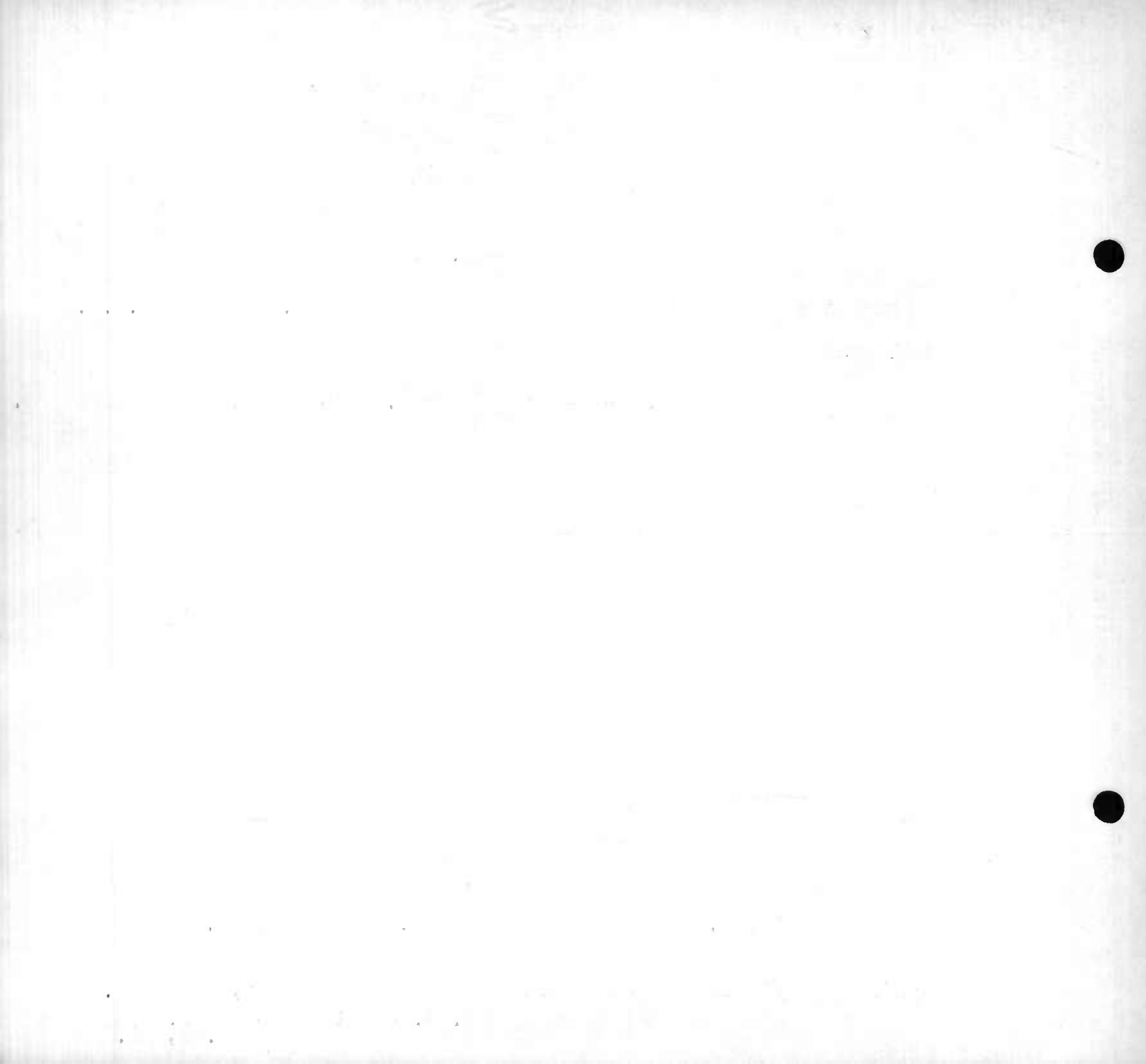
BIRTH NO. 67 5044		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5044	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) John Henry Loeffler		May 22, 1967		6:15 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224		A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave. #21224		26-12	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED, (Specify) Never married)	8. DATE OF BIRTH 5-21-1897	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Loeffler		14. MOTHER'S MAIDEN NAME Elizabeth Peterson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW71 yes WW71		16. SOCIAL SECURITY NO. unknown		17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 191.9 + 002.1 Bacterial spesis		CAUSE OF DEATH Bacterial spesis		INTERVAL BETWEEN ONSET AND DEATH Several days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO		Disseminated Squamous Cell Carcinoma ?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Active pulmonary Tuberculosis			
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-8-19 65 to 5-22-19 67, that (I) (we) last saw the deceased alive on 5-22-19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce Gordon Whipple				23B. DATE SIGNED May 22, 1967	
23C. PHYSICIAN'S NAME (Type) Bruce Gordon Whipple				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/25/67	24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery, Baltimore, Maryland		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967	25B. NAME OF REGISTRAR John A. Moran, Inc.	25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.			

(Continued from page 1)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5045				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5045	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Bertha Whitehurst				May 21, 1967 5 ¹⁰ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
90 Bolton Hill Nursing Home				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore 14-01			
D. STREET ADDRESS (If rural, give location)				Bolton Hill Nursing Home			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
F	W	Widowed	Aug. 29, 1885	81			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Baltimore, Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Emil Funk				Margarete Markalf			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		215-48-3028		Harry E. Whitehurst, 827 Bradhurst Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) <u>arteriosclerotic cardiovascular disease</u>		20 years	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes Mellitus		10 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 12 1946 to May 21 1967 that (we) last saw the deceased alive on May 21 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stiff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Stanley Z. Felsenberg						5/23/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Stanley Z. Felsenberg				1129 E. Baltimore, St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/24/1967		Loudon Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 24 1967		J. E. Felsenberg		H. W. Jenkins & Sons Co.		4905 York Rd Balto. 12, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

Department of Interior

Division of Reclamation

Washington, D. C.

June 1, 1903

m-235

67 5047

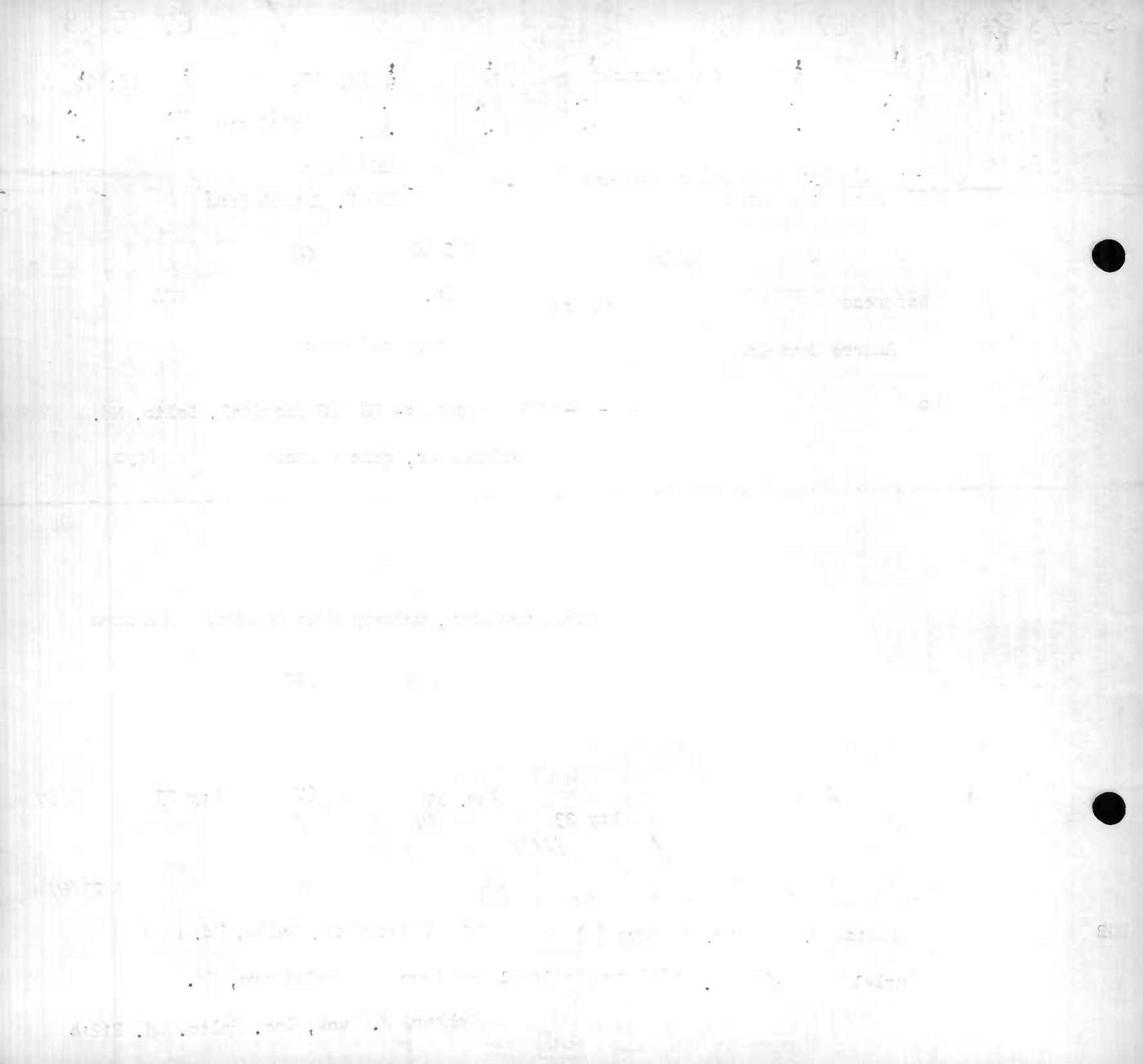
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5047

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) JOHN A. MC DONOUGH		2. DATE AND HOUR PRONOUNCED DEAD May 22, 1967 1:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL (DOA)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21201 D. STREET ADDRESS (If rural, give location) 109 W. Monument Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH December 17, 1898.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant Marine		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 68
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. McDonough		14. MOTHER'S MAIDEN NAME Mary Rossignol	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 129-05-7363A	
17. INFORMANT Miss Adrienne McDonough		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and Hypertensive DUE TO Cardiovascular Disease DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 5/23/67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5/26/67.	
23C. NAME OF CEMETERY or CREMATORY Calvary Cemetery		23D. LOCATION (City, town, or county) (State) Portland, Maine.	
24A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		24B. NAME OF REGISTRAR Robert E. Spitz	
24C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5048	
BIRTH NO. 67 5048		CERTIFICATE OF DEATH		Registered No. 67 5048	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Agnes Mary Selenski		2. DATE AND HOUR OF DEATH May 23, 1967 12: 05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive		A. STATE Md. Baltimore B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 208 N. Branch Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 7/3/06	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Andrew Cawacka		14. MOTHER'S MAIDEN NAME Mary Walislaus	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 189-05-6877		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Peritonitis, generalized		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II Adenocarcinoma, primary site unknown		Unknown	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr. 17 19 67 to May 23 19 67, that (I) (we) last saw the deceased alive on May 23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael E. Pelcsar M.D.				23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) Michael E. Pelcsar, SA Surg (R)		23D. ADDRESS US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/26/67		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto, Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5049					CERTIFICATE OF DEATH				
Registered No. 67 5049									
1. NAME OF DECEASED (Type or Print) DORSEY, CLAUDE Worthington					2. DATE AND HOUR OF DEATH 5-13-67 9am M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY Prince Georges.				
FULL NAME OF HOSPITAL OR INSTITUTION KESWICK 700 WEST 40th STREET BALTIMORE, Md. 21211					C. CITY OR TOWN (If outside City limits, write RURAL and give township) Lanham				
D. STREET ADDRESS (If rural, give location) 315 Talbott Avenue									
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3-2-1881	9. AGE (In years lost birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		11. BIRTHPLACE (State or foreign country) ANNAPOLIS Junction MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME LLOYD DORSEY					14. MOTHER'S MAIDEN NAME Laura Worthington				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth M. Merrick, R.N.		
					ADDRESS KESWICK.		18. INTERVAL BETWEEN ONSET AND DEATH 10 yrs.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 4-20-01					CAUSE OF DEATH (A) Cerebral Arteriosclerosis DUE TO (B) Aspiration DUE TO (C) Arteriosclerotic Heart Disease				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Oesophagus & oesophagitis				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5 19 5-13 to 19 67 , that (I) (we) last saw the deceased alive on 5-12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Elizabeth M. Merrick, R.N. M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 5-13-67	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-15-67		24C. NAME of CEMETERY or CREMATORY Dorsey Family		24D. LOCATION (City, town or county) (State) Annapolis Junction Md			
25A. DATE RECEIVED BY HEALTH DEPT. MAY 16 1967		25B. NAME OF REGISTRAR Walter C. ...		25C. FUNERAL DIRECTOR Walter C. ...					

1. 1st of January

2. 2nd of January

3. 3rd of January

4. 4th of January

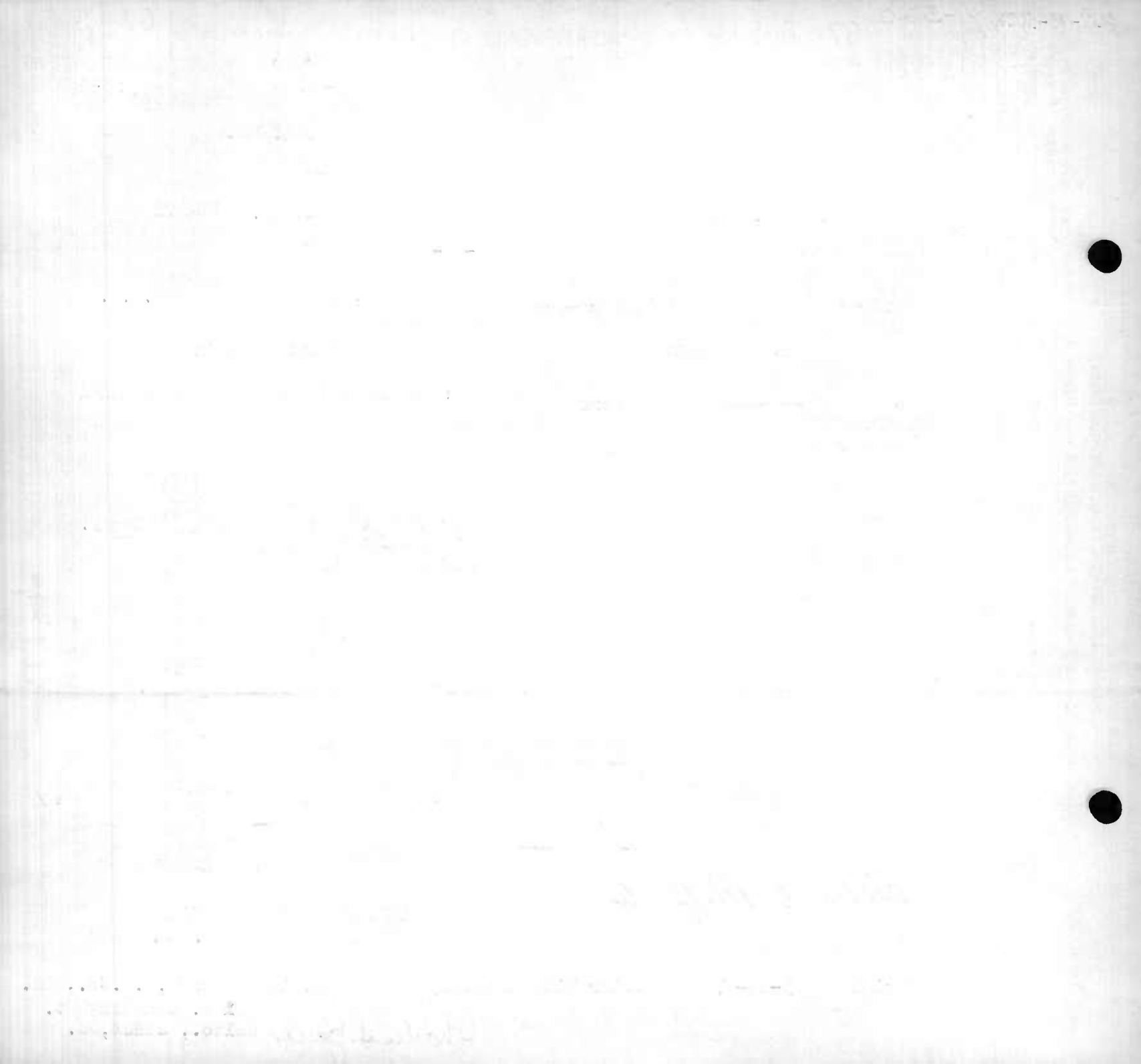
5. 5th of January

6. 6th of January

7. 7th of January

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

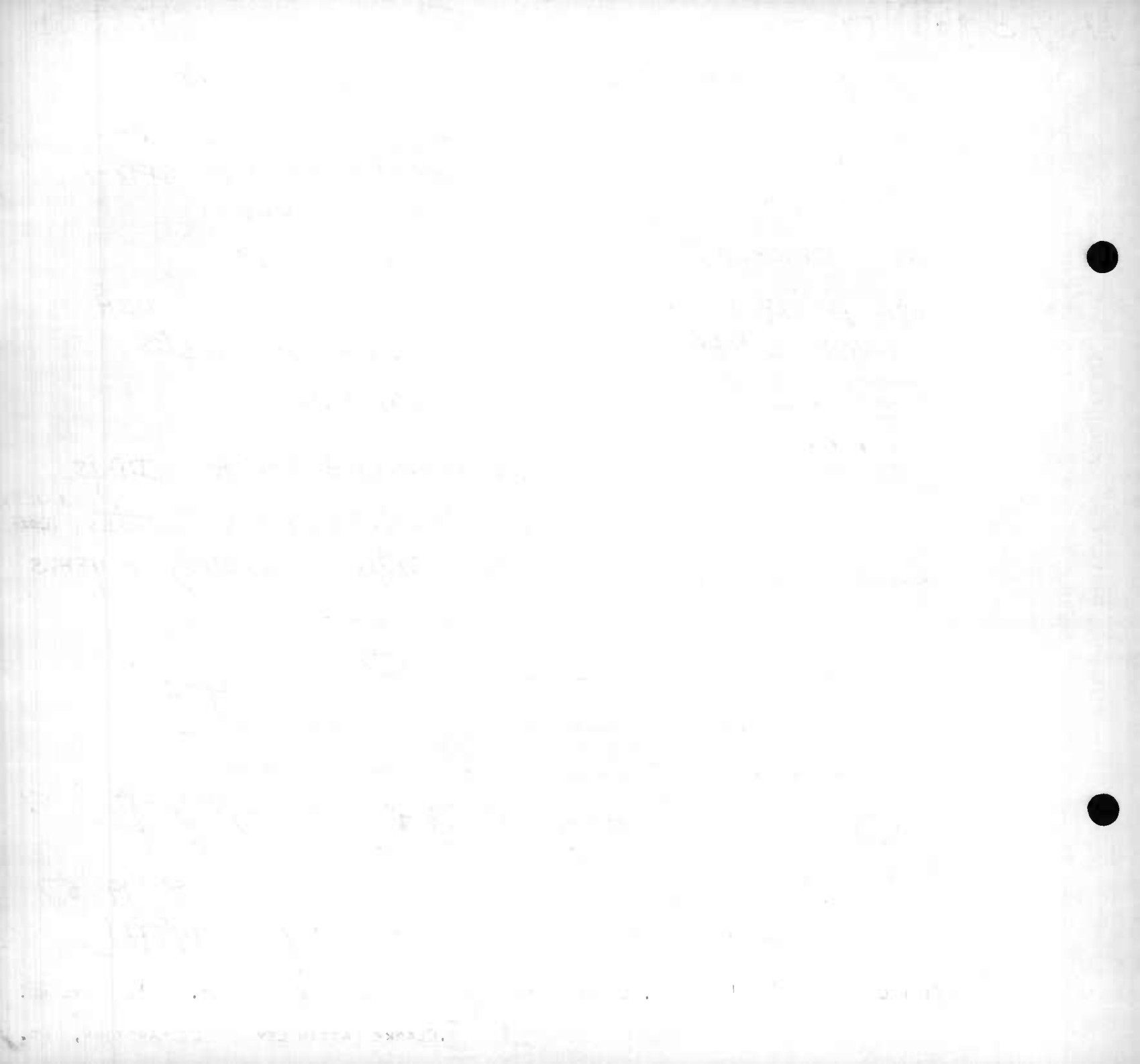
BIRTH NO. 67 5050		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5050	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MICHAEL YOUNG		2. DATE AND HOUR OF DEATH 5-21 - 1967 3:35P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE COUNTY 53-00 D. STREET ADDRESS (If rural, give location) RTE 15 CLARKS PT. RD. BOX 72			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 8-28-86	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Maintenance-Man		11. BIRTHPLACE (State or foreign country) MARYLAND, BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE Young		14. MOTHER'S MAIDEN NAME SUSIE Susan Klein	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS BCH:RECORDS 4940 EASTERN AVENUE 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Metastatic Prostatic Ca with myelothic anemia DUE TO (C) ASCVD with mild CHF		INTERVAL BETWEEN ONSET AND DEATH 24hrs 3yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/51 19 67 to 5/21 19 67, that (I) (we) lost saw the deceased alive on 5/21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Richard M. Maffezzoli		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Richard Maffezzoli		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-24-67		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Highway, A.A.Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967		25B. NAME OF REGISTRAR Charles S. Geiler		25C. FUNERAL DIRECTOR 901 S. Conkling St. Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5051	
BIRTH NO. 67 5051		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE E HAMILTON		2. DATE AND HOUR OF DEATH 5/19/67 10:25 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY St Mary Co.			
5. SEX M		6. RACE CRUCASIAN		7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto AGENCY		10B. KIND OF BUSINESS OR INDUSTRY AUTO AGENCY		8. DATE OF BIRTH 10/21/87	
13. FATHER'S NAME JOHN E. HAMILTON		14. MOTHER'S MAIDEN NAME CECELIA MILES		9. AGE (in years last birthday) 79	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. ?		11. BIRTHPLACE (State or foreign country) MARYLAND	
17. INFORMANT PATIENT		12. CITIZEN OF WHAT COUNTRY? USA			
18. 154X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO BRONCHO PNEUMONIA (B) DUE TO METASTATIC PULM Ca Rectum (C) Ca Rectum (ADENOC)		INTERVAL BETWEEN ONSET AND DEATH DAYS 1 YEAR 4 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 3 19 67 to May 19 19 67 . that (I) (we) last saw the deceased alive on May 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cost MD		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/19/67	
23C. PHYSICIAN'S NAME (Type) F H COST J MD		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/22/67		24C. NAME of CEMETERY or CREMATORY ST. ALOYSIUS CEMETERY	
24D. LOCATION (City, town, or county) (State) LEONARDTOWN ST. MARY'S MARYLAND.		25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967			
25B. NAME OF REGISTRAR W. CLARKE MATTINGLEY		25C. FUNERAL DIRECTOR LEONARDTOWN, MD.			



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHNATHAN F. KING

2. DATE AND HOUR PRONOUNCED DEAD

5-21-67

10:15 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4527 Ridge Drive 21229

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

10/4/46

9. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Assr. Mgr.

10B. KIND OF BUSINESS OR INDUSTRY

R & D Books

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Mitchell L. King

14. MOTHER'S MAIDEN NAME

Cora E. Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-50-3376

17. INFORMANT

Mitchell L. King 4527 Ridge Drive 21229

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hemopericardium with tamponade
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Dissecting aneurysm of aorta
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-22-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/26/67

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 24 1967

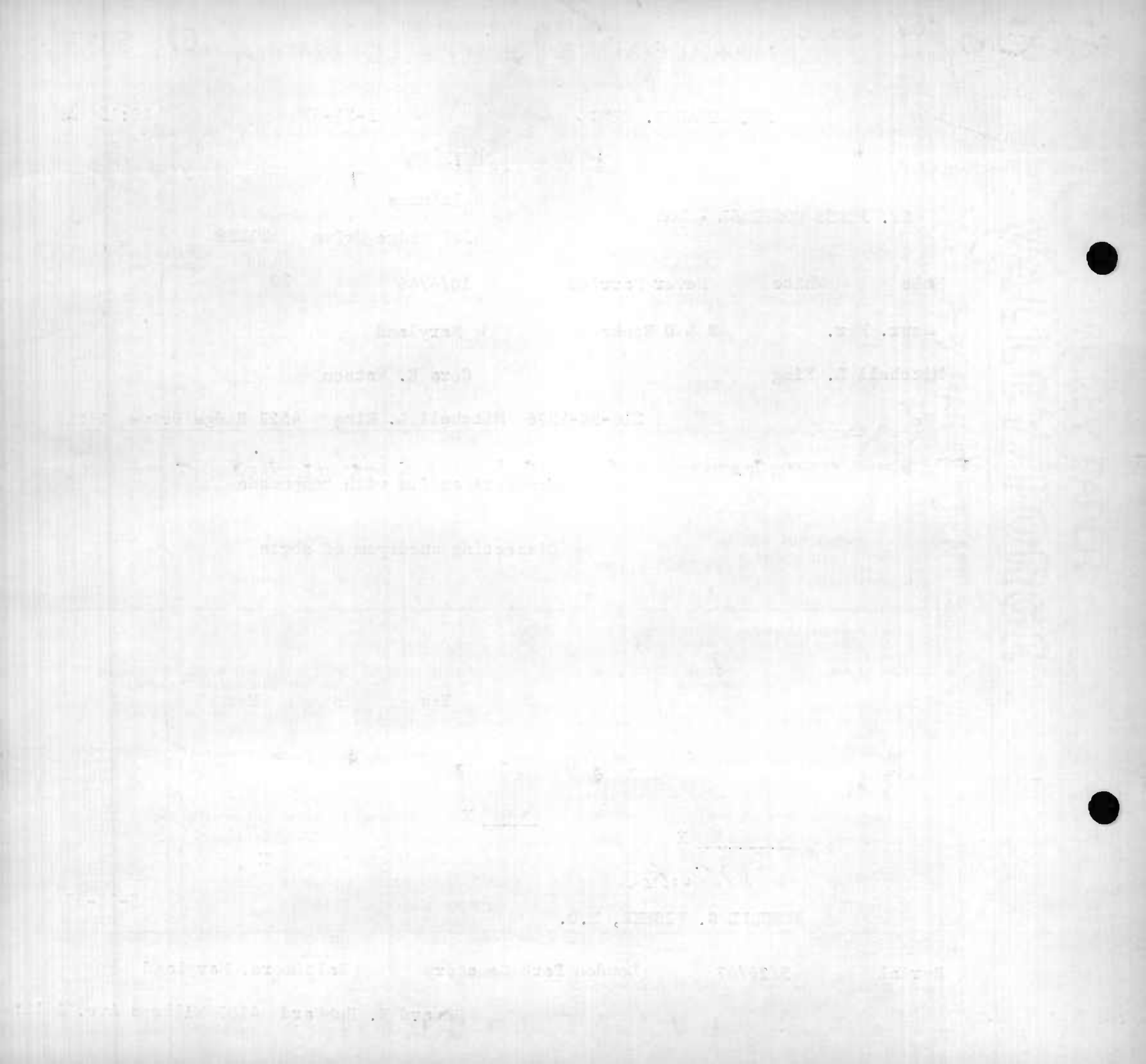
24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Howard H. Hubbard 4107 Wilkens Ave. 21229

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5053	
BIRTH NO. 67-094428		M.E. CASE NO. 5053		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BABY GIRL LATHAN,			2. DATE AND HOUR OF DEATH 5/22/67 10³⁵ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 18 D. STREET ADDRESS (If rural, give location) 1744 MONTPELIER ST.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5-20-1967	9. AGE (In years lost (months)) 2 DAYS	If Under 1 Yr. Months Days Hours Min. 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME CORNELIUS PRYOR			14. MOTHER'S MAIDEN NAME SUSAN LATHAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Prematurity ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Prematurity DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2 Days		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/20 19 67 to 5/22 19 67 , that (I) (we) last saw the deceased alive on 5/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. R. Cohen M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5/22/67	
23C. PHYSICIAN'S NAME (Type) DR. I.R. COHEN		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 5-23-67		24C. NAME of CEMETERY or CREMATORY JOHNS HOPKINS Hosp.	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. MAY 24 1967			
25B. NAME OF REGISTRAR John E. Topham		25C. FUNERAL DIRECTOR 5 HOSPITAL DISPOSAL			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5054	
BIRTH NO. 67 5054		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) JOHN C. POZNANIAK			2. DATE AND HOUR OF DEATH 5-21-67 7.00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY U.S.A. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 1-02 D. STREET ADDRESS (If rural, give location) 634 S. STREEPER ST. BALTO 24.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JUNE 19, 1904	9. AGE (In years last birthday) 59 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FINISHING & PLATING		10B. KIND OF BUSINESS OR INDUSTRY GLENN L. MARTIN CO.	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM POZNANIAK			14. MOTHER'S MAIDEN NAME Maryanna ??		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-6575	17. INFORMANT ADDRESS NORTH CHARLES GENERAL HOSPITAL		
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) UNDIFFERENTIATED BRONCHIAL DUE TO CARCINOMA WITH METASTASIS (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 27 days.		
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4-15-1967 to 5-21-1967, that (I) (we) last saw the deceased alive on 5-21-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chanthana Suddhimondala M.D.			23B. DATE SIGNED 5-21-67		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Dr. CARLOS ARANAGA			23D. ADDRESS M.D. 5428 SINCLAIR LANE 21206 BALTO, MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/24/67	24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR'S ADDRESS 2829 Hudson St. Balto. Md.	

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

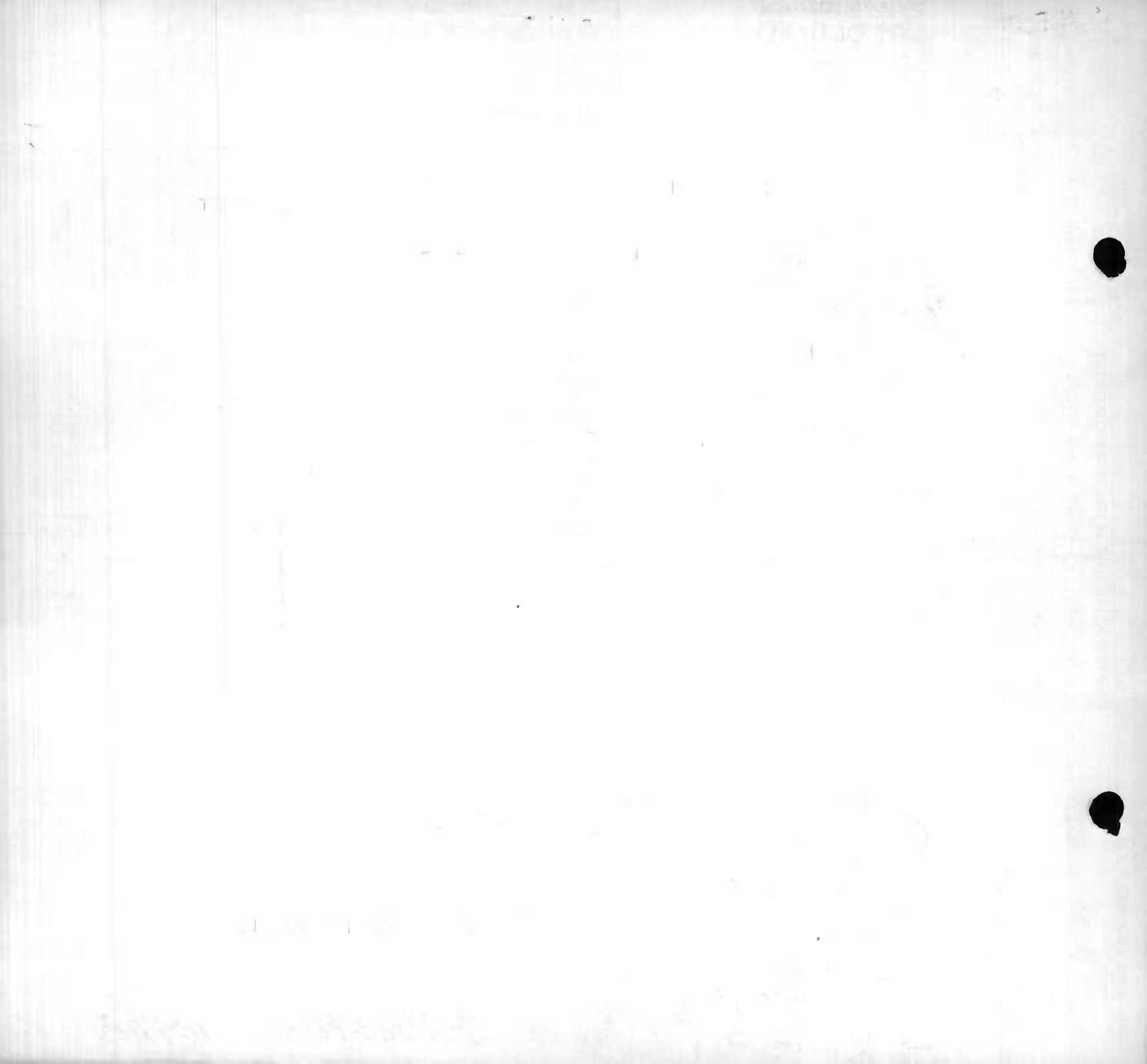
Page 2 of 2

Page 2 of 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department	
BIRTH NO.		67 5055		Registered No. 67 5055	
M.E. CASE NO.				1. NAME OF DECEASED	
(Type or Print)				ALEXANDER RUFFIN	
2. DATE AND HOUR OF DEATH				5/23/67 7:55 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
3 THE JOHNS HOPKINS HOSPITAL				MARYLAND	
5. SEX				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
MALE		NEGRO		BALTIMORE	
6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		D. STREET ADDRESS (If rural, give location)	
MALE		MARRIED		1726 EAST LANVALE STREET	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		10. CITIZEN OF WHAT COUNTRY?	
3-10-10		57		12. CITIZEN OF WHAT COUNTRY?	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Sussex County Md.		14. MOTHER'S MAIDEN NAME		JOHN RUFFIN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH		ADDRESS	
331X I		Intracerebral Hemorrhage		Pattie Ruffin 1726 E. Lanvale St	
ANTECEDENT CAUSES		Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		NOT A MEDICAL EXAMINER'S CASE		M.D.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CHIEF OR ASST. MEDICAL EXAMINER		M.D.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6		No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		22. I certify that (I) (this hospital) attended the deceased from 5/23 1967 to 5/23 1967, that (I) (we) last saw the deceased alive on 5/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
R. Rampton		5/23/67		R. R. RAMPTON	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		May 24/67		Bald Natl Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 25 1967		R. E. Jackson		Walter E. Ellickson 1129 N. Carroll St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5056		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5056	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Leola Johnson</u>			2. DATE AND HOUR OF DEATH <u>5-21-67</u> <u>10:00 P. M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>			A. STATE <u>Maryland</u>		
			B. COUNTY <u>Baltimore</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>8-03</u>		
			D. STREET ADDRESS (If rural, give location) <u>1321 N. Montford Ave.</u>		
5. SEX <u>Female</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>widow</u>	8. DATE OF BIRTH <u>1-6-1891</u>	9. AGE (In years lost birthday) <u>76</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
13. FATHER'S NAME <u>Clarence Brown</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-3802</u>	17. INFORMANT <u>Mrs Amy Johnson</u> ADDRESS <u>1321 N. Montford Ave</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <u>Myocardial Infarction</u> <u>hours</u>		
			(B) <u>Cardiovascular Heart Disease</u> <u>years</u>		
			(C) <u>Diabetes Mellitus</u> <u>years</u>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Glaucoma, Blindness Left Eye</u> <u>Months</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>None</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> 19 <u>67</u> to <u>5/21</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/21</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John H. Daughtery, M.D.</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>5/24/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN H DAUGHTERY MD</u> M.D.				23D. ADDRESS <u>2443 E. Preston Street Baltimore, Maryland 21213</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-25-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION <u>Anne Arundel Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 25 1967</u>		25B. NAME OF REGISTRAR <u>Randolph J. Collick</u>		25C. FUNERAL DIRECTOR'S ADDRESS <u>2431 E. Oliver St.</u>	

JOHN H. CRONIN, MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>67 5057</u>	
BIRTH NO. <u>67 5057</u>											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>POHLE, HERBERT FRANK</u>						2. DATE AND HOUR OF DEATH <u>MAY 23, 1967</u> <u>12:15AM</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u>			(If not in hospital or institution, give street address or location) <u>ST. AGNES HOSPITAL</u> <u>WILKENS & CATON AVES.</u> <u>BALTO. 29, MD.</u>			A. STATE <u>MD</u>		B. COUNTY <u>BALTO. 29</u>			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>					
						D. STREET ADDRESS (If rural, give location) <u>40 S. MONASTERY AVE.</u>					
5. SEX <u>MALE</u>		6. RACE <u>CAUCASION</u>		7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>MARRIED</u>		8. DATE OF BIRTH <u>09-19-90</u>		9. AGE (In years last birthday) <u>76</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-PAINTER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>PAINTER</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES POHLE</u>						14. MOTHER'S MAIDEN NAME <u>ELLA DOYLE</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WAR I</u>				16. SOCIAL SECURITY NO. <u>212-03-2330</u>		17. INFORMANT ADDRESS <u>ST. AGNES RECORDS; WILKENS & CATON AVES.</u>					
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> (B) <u>PNEUMONITIS</u> (C) <u>PULMONARY EMPHYSEMA</u>					
INTERVAL BETWEEN ONSET AND DEATH											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 10,</u> 19 <u>67</u> to <u>MAY 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 23, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>R. Revilla</u>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>MAY 23, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. REVILLA</u>								23D. ADDRESS X <u>ST. AGNES HOSPITAL</u> <u>WILKENS & CATON AVES. BALTO 29, MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>May 25, 1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cem.</u>				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 25 1967</u>				25B. NAME OF REGISTRAR <u>G. E. Schwab</u>				25C. FUNERAL DIRECTOR ADDRESS <u>G. E. Schwab 3512 Frederick Ave. Balto. Md.</u>			

1. The first part of the report is a general introduction to the subject.

2. The second part is a detailed description of the methods used.

3. The third part is a discussion of the results.

4. The fourth part is a conclusion.

5. The fifth part is a list of references.

6. The sixth part is a list of figures.

7. The seventh part is a list of tables.

8. The eighth part is a list of appendices.

9. The ninth part is a list of footnotes.

10. The tenth part is a list of symbols.

11. The eleventh part is a list of abbreviations.

12. The twelfth part is a list of acronyms.

13. The thirteenth part is a list of definitions.

14. The fourteenth part is a list of equations.

15. The fifteenth part is a list of figures.

16. The sixteenth part is a list of tables.

17. The seventeenth part is a list of appendices.

18. The eighteenth part is a list of footnotes.

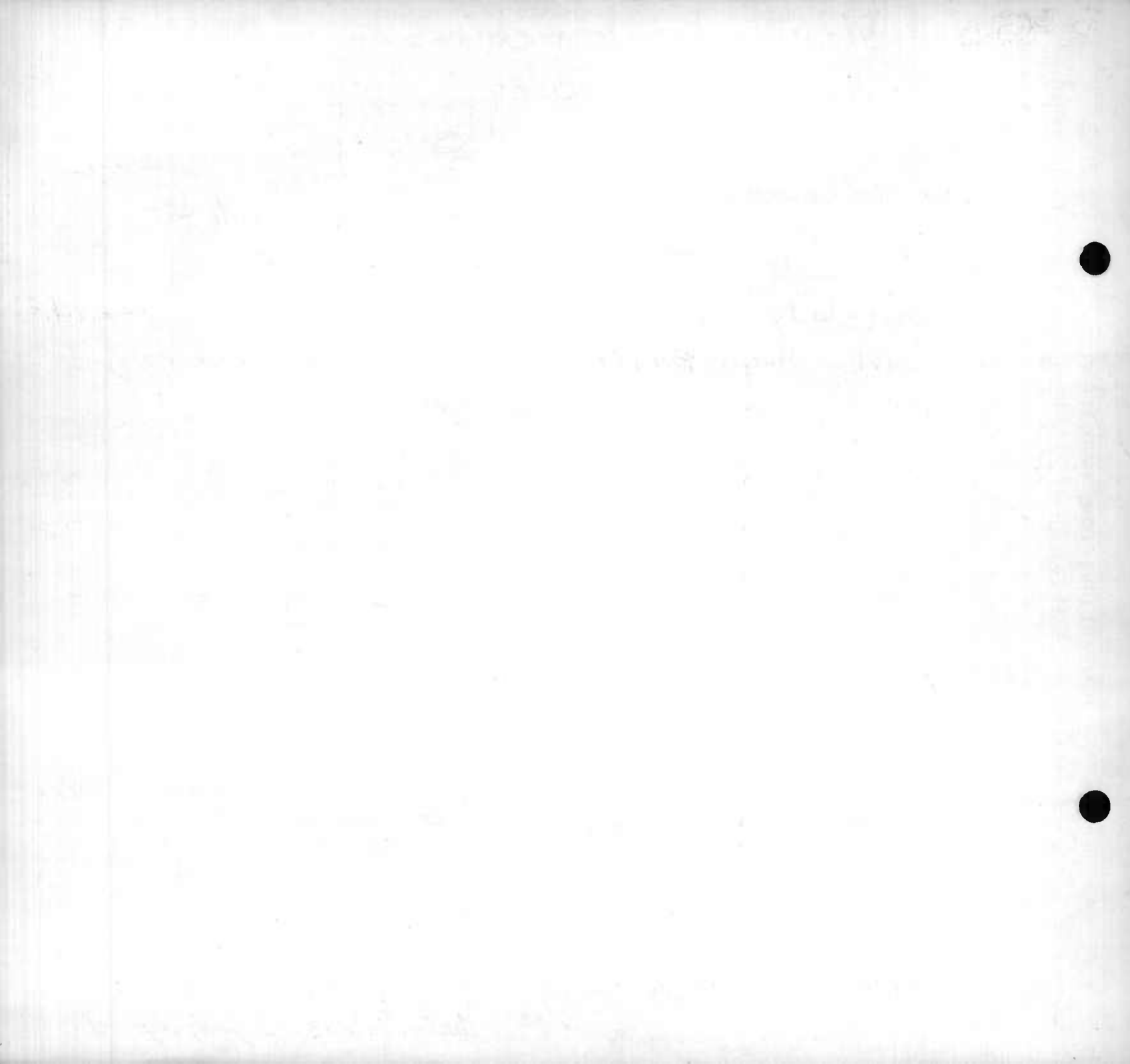
19. The nineteenth part is a list of symbols.

20. The twentieth part is a list of abbreviations.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 5058					CERTIFICATE OF DEATH					Registered No. 67 5058				
1. NAME OF DECEASED (Type or Print) <i>Mrs. Johanna Berg</i>										2. DATE AND HOUR OF DEATH <i>5-22-67. 10 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 BON SECOURS HOSPITAL</i>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1222 Cleveland St</i>				
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>5-24-03</i>		9. AGE (In years last birthday) <i>63</i>		If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales lady</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i>		11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>yes U.S.A.</i>				
13. FATHER'S NAME <i>Carl Hugo Bauer</i>						14. MOTHER'S MAIDEN NAME <i>Ronneberger</i>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>						16. SOCIAL SECURITY NO. <i>213-32-8464</i>		17. INFORMANT <i>chart.</i>						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) DUE TO <i>Primary adenocarcinoma of intra-hepatic bile duct. invasion of gall bladder wall</i> (B) DUE TO <i>Cholelithiasis</i> (C) _____			INTERVAL BETWEEN ONSET AND DEATH <i>one & half months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>1 May 5, 67</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Very poor & deep jaundice</i>				20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <i>April 15</i> 19 <i>67</i> to <i>May 22</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>May 22</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>S. W. Amy</i>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>May 22, 67</i>						
23C. PHYSICIAN'S NAME (Type) <i>500 WONG, HONG</i>						23D. ADDRESS M.D. <i>BON SECOURS HOSPITAL</i>								
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>5/26/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Dorsey, Maryland</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 25 1967</i>				25B. NAME OF REGISTRAR <i>R. E. Taylor</i>				25C. FUNERAL DIRECTOR <i>Arthur F. 1328 Sulphur Sp. Rd.</i>						



5-300

67 5059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 5059

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

George E. Scott Sr.

2. DATE AND HOUR OF DEATH

May 24, 1967

5:30 AM.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

00 1601 Webster St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1601 Webster St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Feb. 16, 1885

9. AGE (In years
last birthday)

82

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Painting

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

William Scott

14. MOTHER'S MAIDEN NAME

Wilhelmina Unknown

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

450.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Acute Cardiac Failure

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

Arteriosclerosis

3 yrs. +

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-1-1965 to 5-24-1967,
that (I) (we) last saw the deceased alive on 5-23-1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

5-24-67

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

M.D.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5 28 67

24C. NAME OF CEMETERY or CREMATORY

Fairview Lawn

24D. LOCATION

(City, town, or county)

Onancock, Va.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 25 1967

25B. NAME OF REGISTRAR

M. E. Scott, Jr.

25C. FUNERAL DIRECTOR

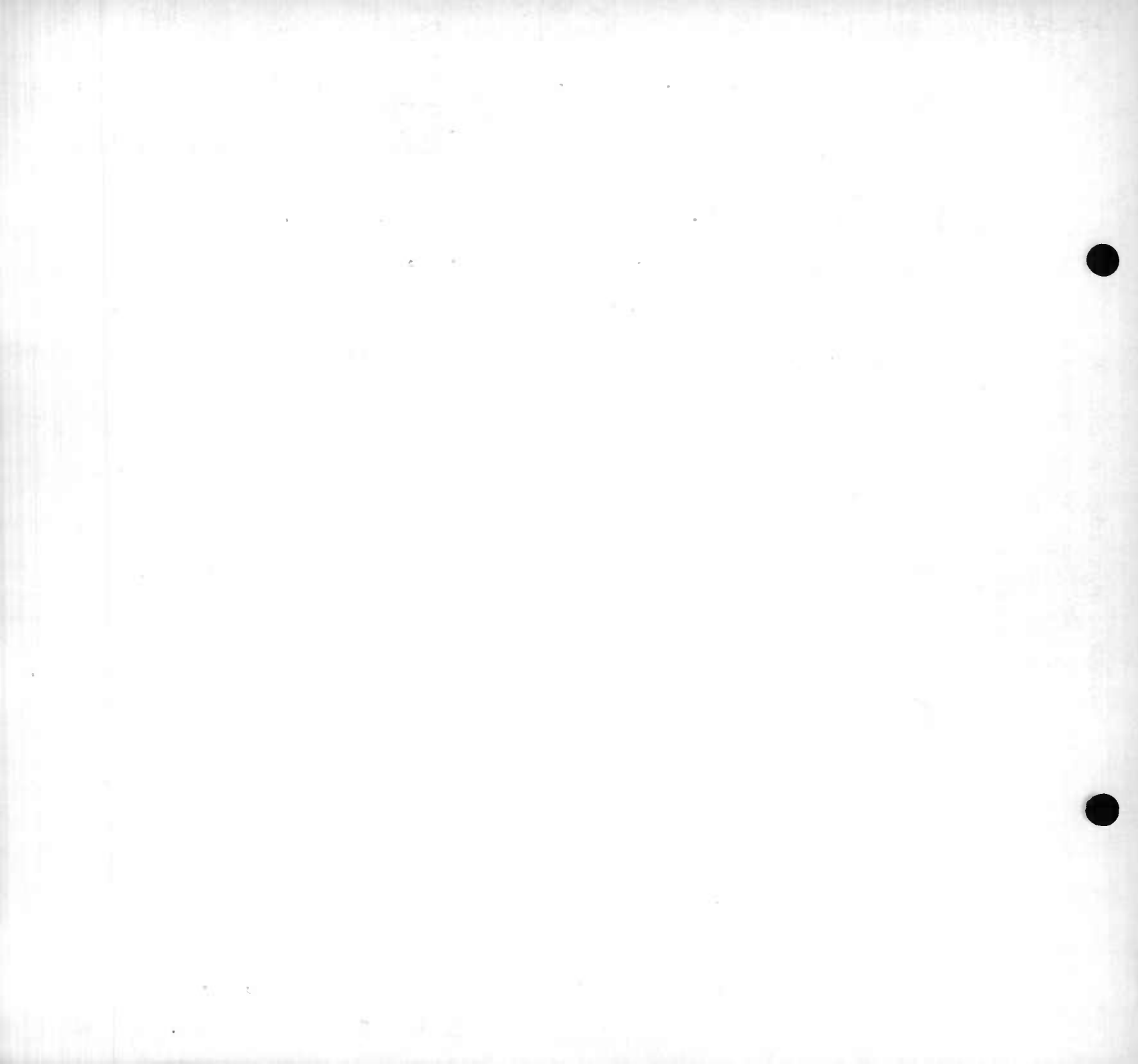
J. D. O'Neil

ADDRESS

130 E. Fort Ave

FUNERAL DIRECTOR: IMPORTANT

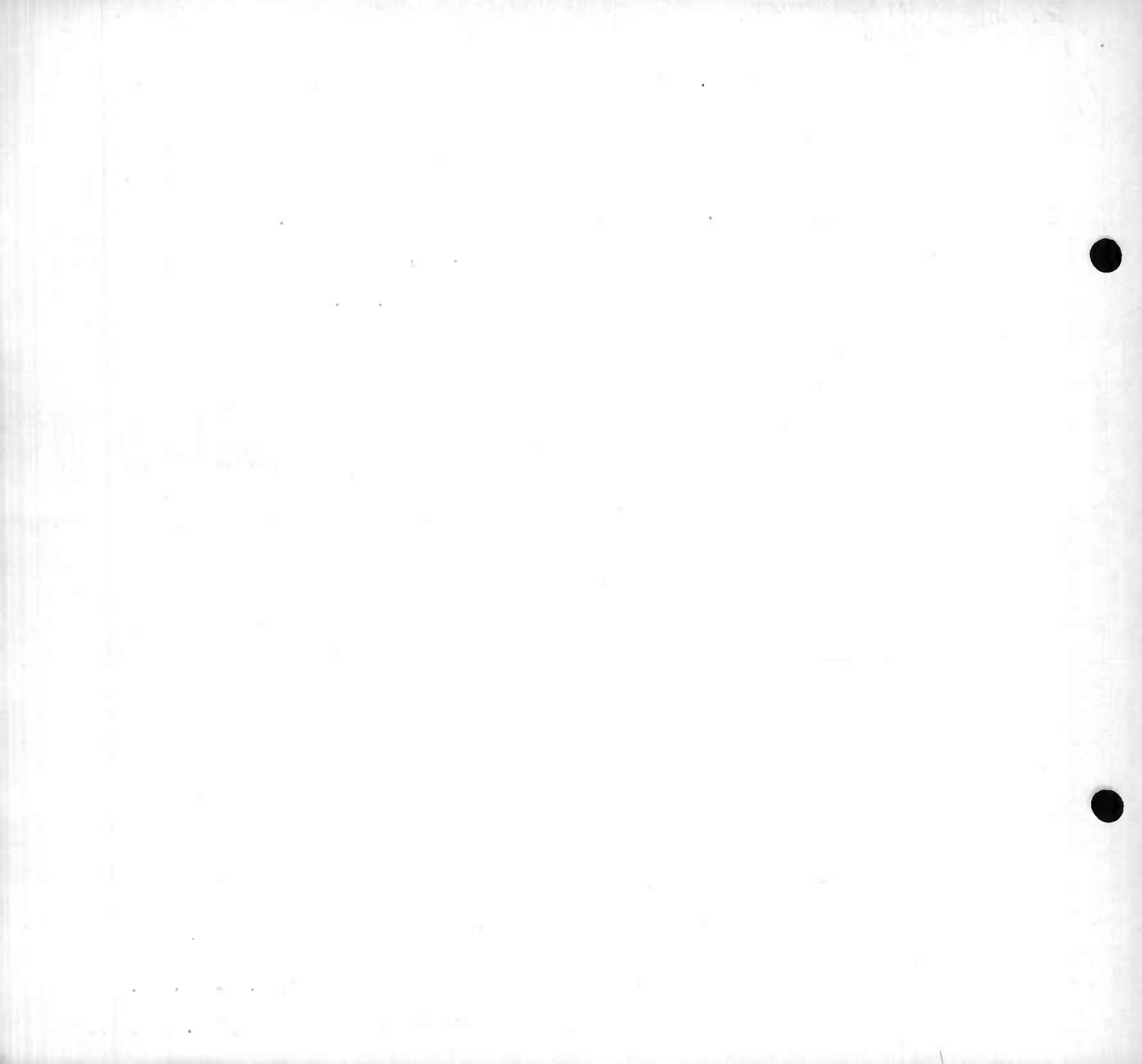
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

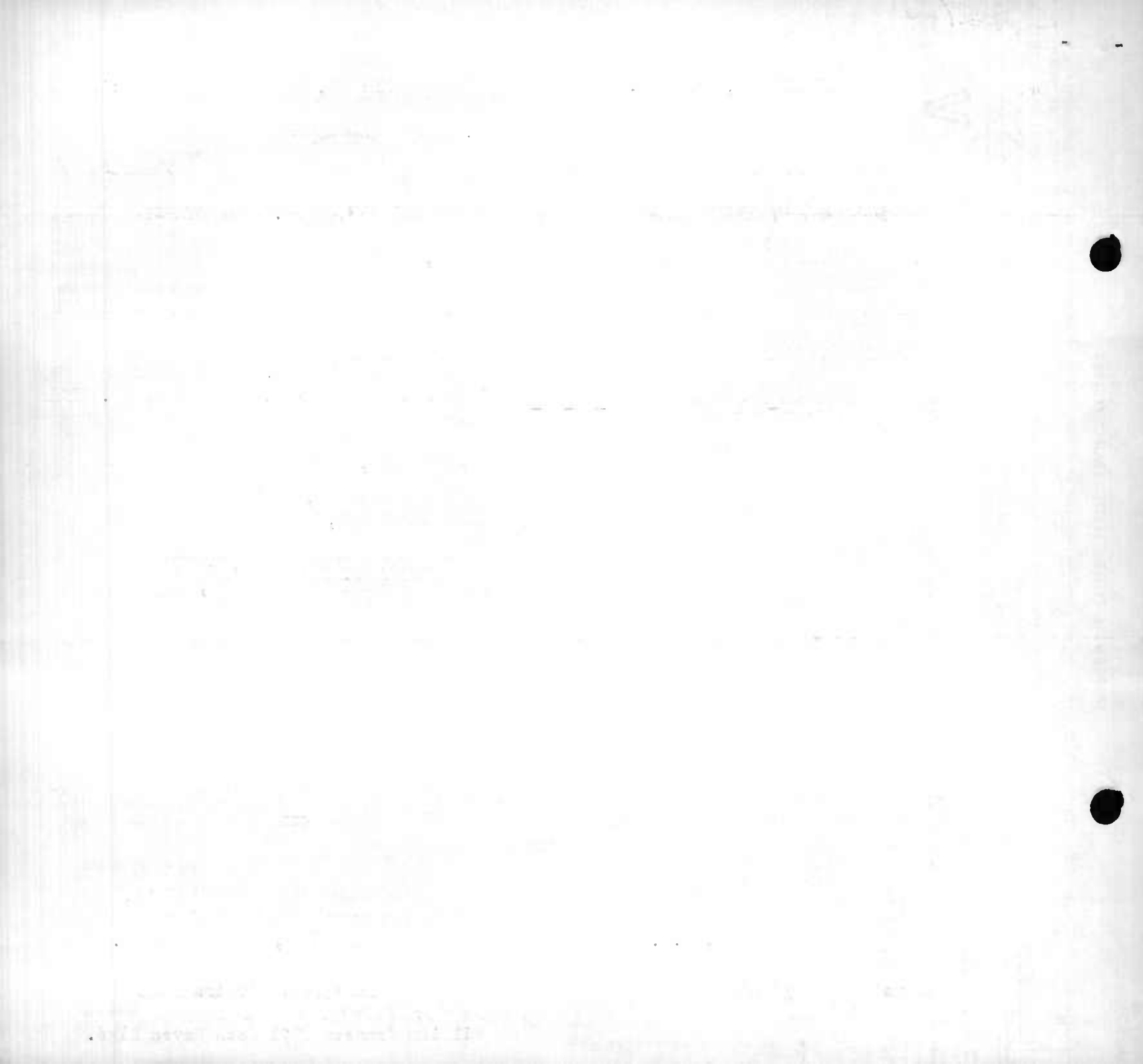
BIRTH NO. 67 5060				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5060	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Marie M. Hiller				2. DATE AND HOUR OF DEATH May 23, 1967 10:30 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2543			
				D. STREET ADDRESS (If rural, give location) 2140 Harmon Ave.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 21, 1895	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Schneider				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same	
18. 492X 14260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Acute Coronary Thrombosis DUE TO (B) Pneumonia, lft DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH minutes - 5 1/2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus						10 yrs +	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/6/58 19 to 5/23/67 19, that (I) (we) last saw the deceased alive on 5/19/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE C. Arthur Rossberg M.D.				23B. DATE SIGNED 5/24/67			
23C. PHYSICIAN'S NAME (Type) C. ARTHUR ROSSBERG M.D.				23D. ADDRESS 2436 WASHINGTON BLVD Baltimore Md. 21230			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5 26 67		24C. NAME of CEMETERY or CREMATORY Cedar Hill		24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Jc Gully		ADDRESS 130 E. Fort Ave	



FUNERAL DIRECTOR: IMPORTANT

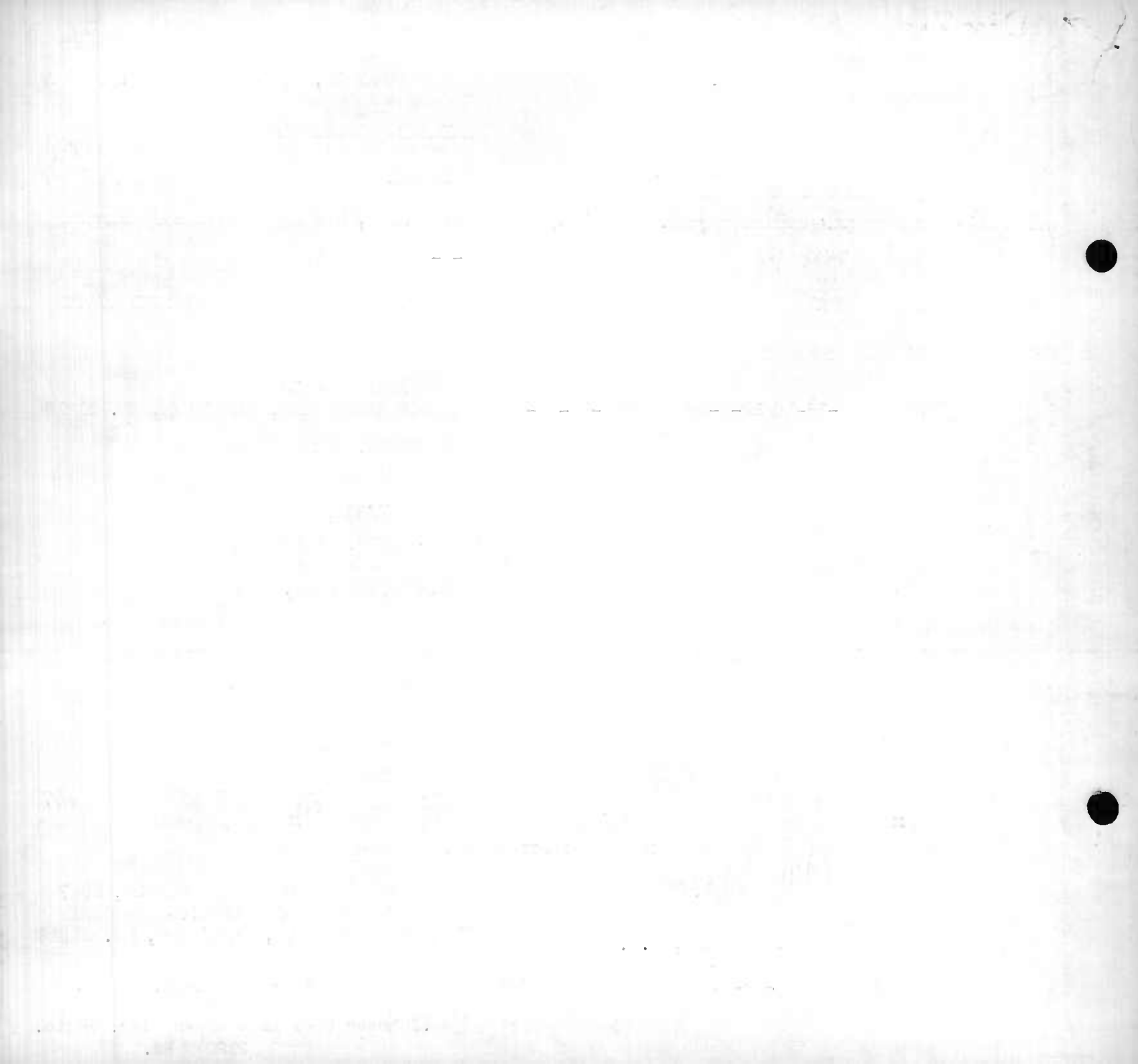
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-421		67 5061		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5061		
BIRTH NO. 67 5061				CERTIFICATE OF DEATH				
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) BLACKBURN, JAMES L.				2. DATE AND HOUR OF DEATH MAY 20, 1967 8:40 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				A. STATE B. COUNTY MARYLAND BALTIMORE				
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 14-01				
				D. STREET ADDRESS (If rural, give location) LAFAYETTE AVE, & ST. JOHN STREET				
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH MAY 27, 1897	9. AGE (in years lost birthday) 69	If Under 1 Yr. Months Days			If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER		10B. KIND OF BUSINESS OR INDUSTRY COAL INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME BEDFORD BLACKBURN				14. MOTHER'S MAIDEN NAME SESSIE JOINES				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 8/22/18-7/10/19				16. SOCIAL SECURITY NO. 236-10-56-00A				
17. INFORMANT VETERANS HOSPITAL RECORDS				3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218				
18. 527.11 CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) BRONCHOPNEUMONIA, BILATERAL				
ANTECEDENT CAUSES				(B) PULMONARY ANTHRACOSIS, MARKED PULMONARY EMPHYSEMA, MODERATELY SEVERE				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) PULMONARY EDEMA & CONGESTION, SEVERE CHRONIC PYELO NEPHRITIS & NEPHROSCLEROSIS, MODERATELY SEVERE				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (X) (this hospital) attended the deceased from MARCH 28 19 67 to MAY 20 19 67, that (X) (we) last saw the deceased alive on MAY 20 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.								
23A. SIGNATURE Allan Johnson				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED MAY 21, 1967		
23C. PHYSICIAN'S NAME (Type) ALLAN JOHNSON, M.D.				23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd, Baltimore, Md. 21218				
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 5/21/67		24C. NAME OF CEMETERY or CREMATORY Manassas, Virginia		24D. LOCATION (City, town, or county) (State)		
25A. DATE RECEIVED BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR William Johnson		25C. FUNERAL DIRECTOR William Johnson		ADDRESS 8521 Loch Raven Blvd.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

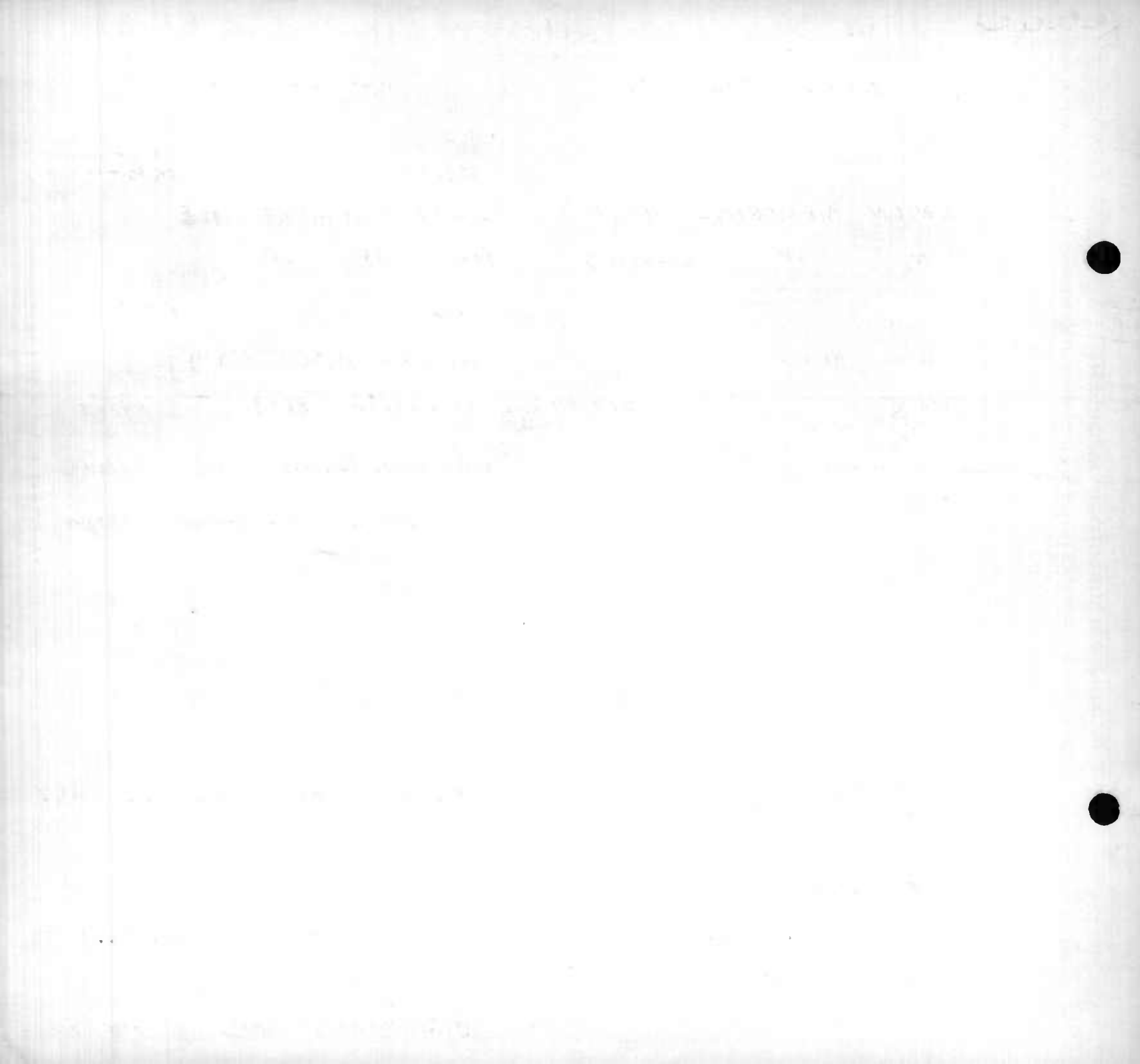
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5062	
BIRTH NO. 67 5062		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) DZENCIOT, ZYGMONT		2. DATE AND HOUR OF DEATH MAY 20, 1967 6:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY BALTIMORE			
VETERANS ADMINISTRATION HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
3900 LOCH RAVEN BOULEVARD		D. STREET ADDRESS (If rural, give location) 2019 SPARK COURT			
BALTIMORE, MARYLAND 21218					
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 4-6-88	9. AGE (In years lost birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHOREMAN			11. BIRTHPLACE (State or foreign country) PODWEZE, RUSSIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME STANLEY DZENCIOT			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6-28-18-12-5-18		16. SOCIAL SECURITY NO. 214-10-07-19		17. INFORMANT VA HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH BRONCHOPNEUMONIA, RIGHT LOWER LOBE (A) DUE TO PULMONARY EMPHYSEMA, ADVANCED (B) DUE TO FIBROUS PLEURITIS, BILATERAL, SEVERE (C) ARTERIO NEPHROSCLEROSIS, MARKED		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from MARCH 15 1967 to MAY 20 1967, that (2) (we) last saw the deceased alive on MAY 20 1967 and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE Allan Johnson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED MAY 21, 1967	
23C. PHYSICIAN'S NAME (Type) ALLAN JOHNSON, M.D.		23D. ADDRESS Veterans Administration Hospital 3900 Loch Raven Blvd, Baltimore, Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-24-67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
				24D. LOCATION (City, town, or county) Baltimore Maryland. (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR Wm. Johnson		25C. FUNERAL DIRECTOR 8521 Loch Raven Blvd. Balto. 20204 Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5063		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5063	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) KEYS Wm. F.				MAY 22 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 26-03	
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) 3241 CLIFMONT AVE	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH FEB 12 1887	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA
10B. KIND OF BUSINESS OR INDUSTRY			14. MOTHER'S MAIDEN NAME AGNES BROUTHAM		
13. FATHER'S NAME Wm. KEYS			17. INFORMANT ELIZABETH KEYS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK			16. SOCIAL SECURITY NO. 217-09-2372		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1			CAUSE OF DEATH (A) Cerebrovascular Accident 1 hour (B) Hypertensive Art. Heart Disease 10 yrs (C)		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1955 to May 22 1967, that (I) (we) last saw the deceased alive on May 15 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Franklin E. Leslie				23B. DATE SIGNED 5-24-67	
23C. PHYSICIAN'S NAME (Type) FRANKLIN E. LESLIE				23D. ADDRESS M.D. 302 East 33rd Street Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/26/67		24C. NAME OF CEMETERY or CREMATORY PARKWOOD	
24D. LOCATION (City, town, or county) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967			
25B. NAME OF REGISTRAR J. G. CONNELLY SONS		25C. FUNERAL DIRECTOR 300 MACE			



C-600

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5064		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5064	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Josephine		2. DATE AND HOUR PRONOUNCED DEAD May 23, 1967 2:25 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 303 N. GILMORE STREET		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 19-01 D. STREET ADDRESS (If rural, give location) 303 N. Gilmore Street	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept 26-1895
9. AGE (In years last birthday) 71		10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail		10B. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Lula Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Vigman Ave	
17. INFORMANT Same		ADDRESS	
18. 154X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of rectum with metastases DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Werner U. Spitz, M.D. DATE SIGNED 5/23/67			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5-25-67	
23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		23D. LOCATION (City, town, or county) (State) Baltimore	
24A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		24B. NAME OF REGISTRAR Chap Wilson	
24C. FUNERAL DIRECTOR Chap Wilson		24D. ADDRESS 1000 Brantley Ln	

WILLIAM J. BORDEN

WILLIAM J. BORDEN

WILLIAM J. BORDEN

WILLIAM J. BORDEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5065		CERTIFICATE OF DEATH			
M.E. CASE NO. 67 5065					
1. NAME OF DECEASED (Type or Print) Rene Harry Kohler		2. DATE AND HOUR OF DEATH May 21, 1967		7:58 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Park Drive		A. STATE NJ B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Wenonah			
		D. STREET ADDRESS (If rural, give location) 544 Le High Rd.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 3/7/31	9. AGE (In years last birthday) 36	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NJ	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Rene Kohler			14. MOTHER'S MAIDEN NAME Marie Lapp		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) yes USAF 1950-1954		16. SOCIAL SECURITY NO. 142-24-3578		17. INFORMANT ADDRESS US PHS Hospital, Balto, Md.	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Embryonal cell carcinoma (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					Months
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 20 19 66 to May 21 19 67 , that (I) (we) last saw the deceased alive on May 21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael E. Pelczar M.D.				23B. DATE SIGNED 5/22/67	
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surg (R) M.D.				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/25/67		24C. NAME OF CEMETERY or CREMATORY Collington	
24D. LOCATION (City, town, or county) (State) Clarksboro N.J.					
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS 3615-17-19	

W. J. Harrison

James W. Harrison

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5066		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5066	
M.E. CASE NO.		1. NAME OF DECEASED HERBERT L. MOORE, HERBERT JR.		2. DATE AND HOUR OF DEATH 5-24-67 6:50 A.M.	
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland		C. CITY OF TOWN (If outside city limits, write FULL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 4034 Park Hgts. Ave.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married Divorced	8. DATE OF BIRTH 5-30-1912	9. AGE (In years last birthday) 54 years	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab DRIVER		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph A Moore		14. MOTHER'S MAIDEN NAME Edith DAVIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes - WWII - Army		16. SOCIAL SECURITY NO. 212-18-3125		17. INFORMANT Edward A Moore - 3317 Spaulding Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA - FAILURE		19. CAUSE OF DEATH (A) Hepatic Coma - failure - 2 days (B) Cirrhosis of liver + Acute cholecystitis (C) Pulmonary Emphysema + Congestive Cardiac Failure		20. INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5-13-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute cholecystitis		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-26-67 19 to 5-24-1967 , that (I) (we) last saw the deceased alive on 5-24-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anil M. Joshi		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-24-67	
23C. PHYSICIAN'S NAME (Type) Dr. ANIL M. JOSHI		23D. ADDRESS Lutheran Hospital of Maryland, 730 Ashburton Baltimore - Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-27-67		24C. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery	
24D. LOCATION Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR ELLSWORTH ARNA COST	
25C. FUNERAL DIRECTOR ELLSWORTH ARNA COST		25D. ADDRESS 4600 Liberty Hgts.			

6/29/67 - Divorce Decree - Circuit Court of Baltimore City - May Term - 1943.

Vivienne V. Moore divorced A Vinculo Matrimonii from Herbert Lee Moore.

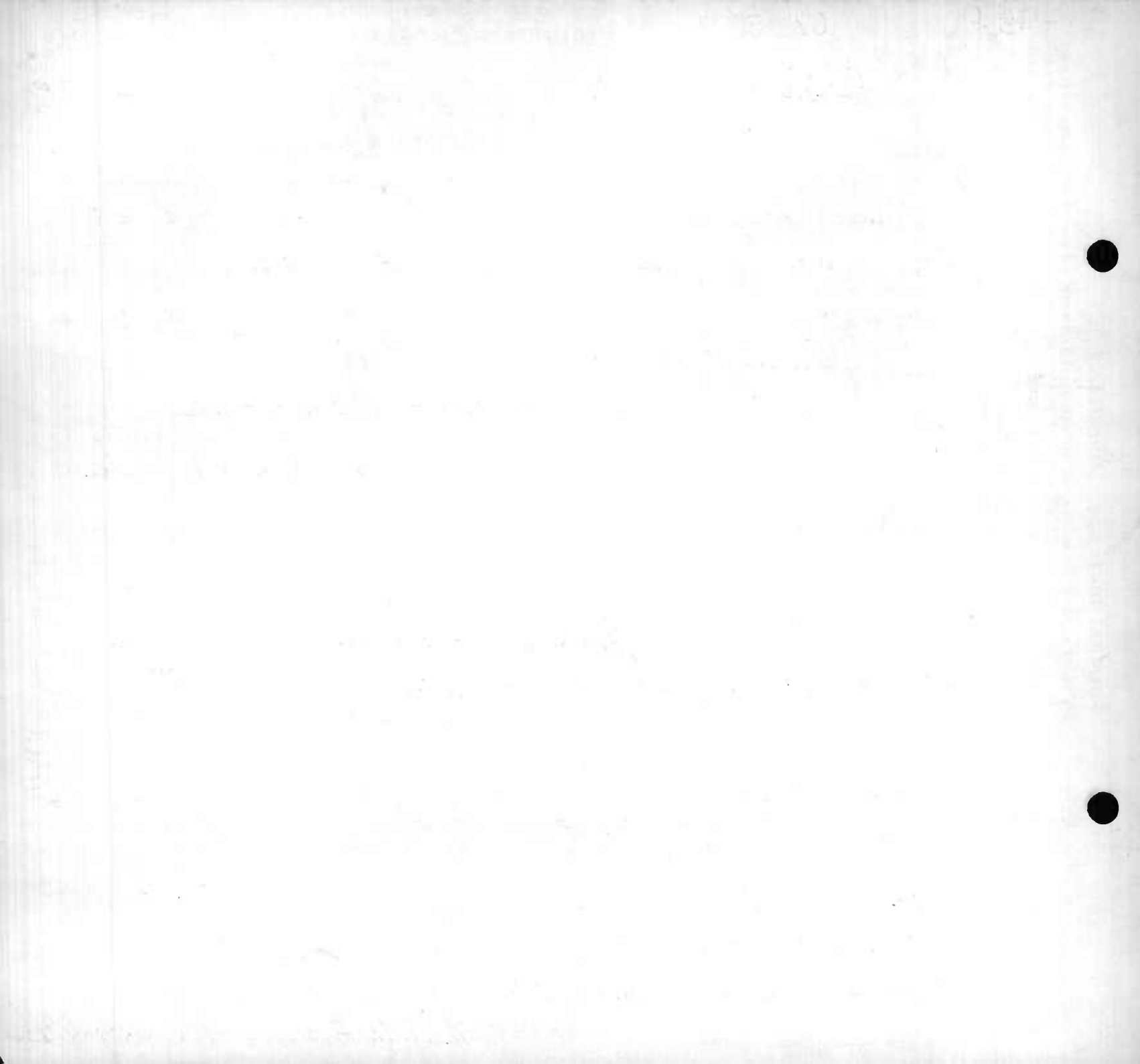
Signed Henry J. Ripperger, Clerk Circuit Court of Baltimore City.

H. Ripperger

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

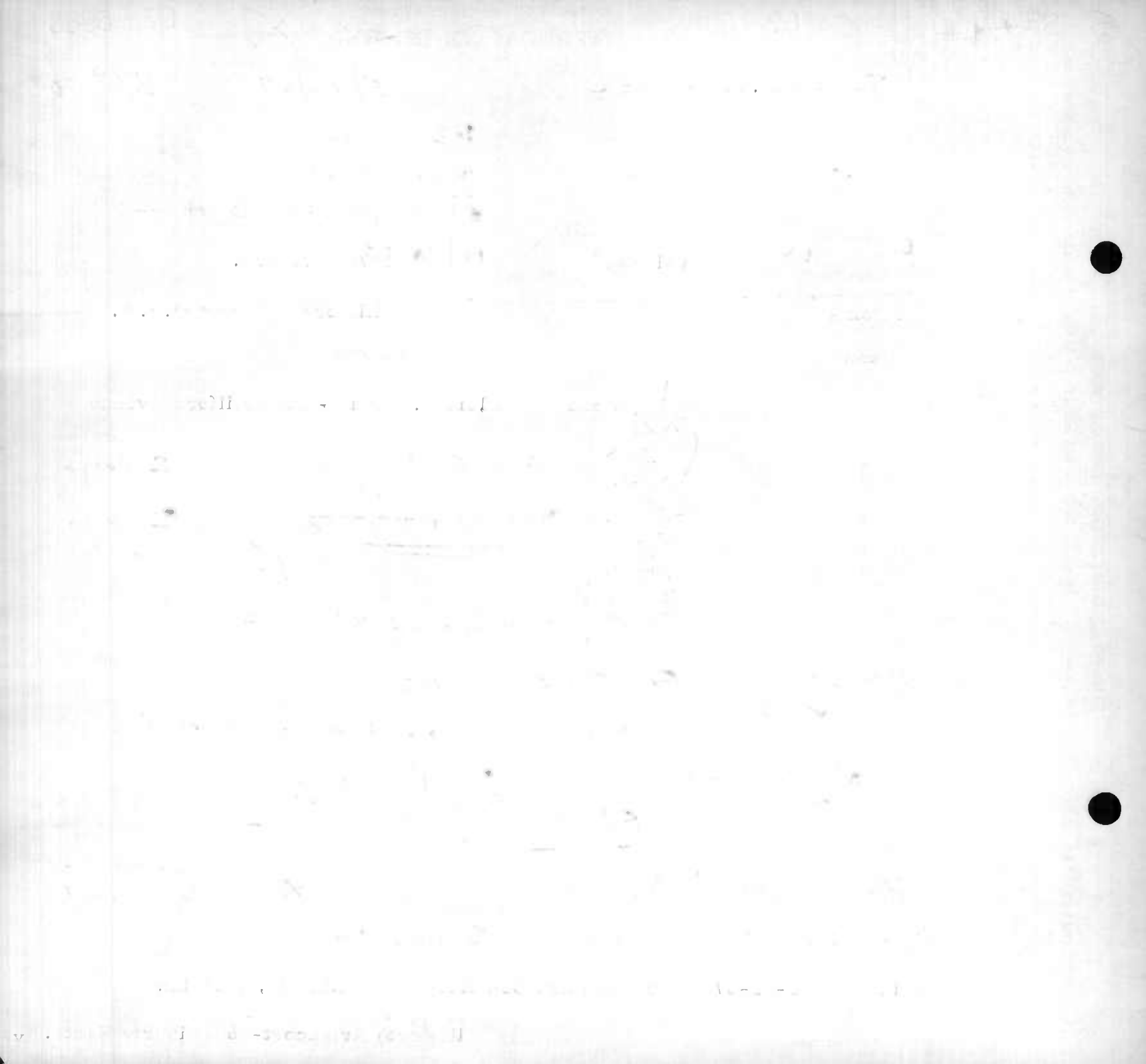
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5067	
BIRTH NO. 67 5067		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Dolin Ethel M</i>		2. DATE AND HOUR OF DEATH <i>May 23 - 67 12:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>H2 Sinai Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>Balt. Co.</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>6039 Gwynn Oak #7</i>			
5. SEX <i>Fe.</i>	6. RACE <i>Cauc.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6/2/34</i>	9. AGE (In years last birthday) <i>32</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Ernest Chalk</i>				14. MOTHER'S MAIDEN NAME <i>Reed</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-30-5788</i>		17. INFORMANT <i>Robert L Dolin - Same</i>		ADDRESS	
18. <i>331 XI-260X</i>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <i>Intracerebral hemorrhage</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes mellitus</i>							
19A. DATE OF OPERATION <i>5/22/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Respiratory arrest</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>no</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>5/20/67</i> 19 <i>67</i> to <i>5/23</i> 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>5/23/67</i> 19 <i>67</i> and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Ernest H. Hesselberg</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/23/67</i>	
25C. PHYSICIAN'S NAME (Type) <i>Ernest H. Hesselberg</i>				23D. ADDRESS <i>Sinai Hospital</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-26-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 25 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>Ellsworth Armacos</i>		ADDRESS <i>4600 Liberty Hgts</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5068	
BIRTH NO. 67 5068		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SARAH M. SCHENKEL		2. DATE AND HOUR OF DEATH 5/23/67 1:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF INSTITUTION 42 SINAI HOSP		A. STATE MD B. COUNTY BA Balto. Co.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00			
		D. STREET ADDRESS (If rural, give location) 5214 MILFORD AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11/30/1875	9. AGE (In years last birthday) 91 Yrs.	10. Under 1 Yr. Months: 0 Days: 0 Hours: 0 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Penn		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Elsie L. Lewis - 3214 Milford Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, i.e., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last.		MEDICAL EXAMINER'S CERTIFICATION APPROVED BY 2-5-67		2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Fracture of RT. Hip.			
19A. DATE OF OPERATION 5/20/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FX RT HIP		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5214 MILFORD AVE 53-00	
21D. TIME OF INJURY (APPROX.) 5/19/67 2PM		21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input checked="" type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR? PT FELL	
22. I certify that (1) (this hospital) attended the deceased from 5/19 1967 to 5/23 1967, that (I) (we) last saw the deceased alive on 5/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley Friedler		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) STANLEY FRIEDLER		23D. ADDRESS SINAI HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-25-67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR W. B. F. F. F.		25C. FUNERAL DIRECTOR ADDRESS E. O. F. F. F.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5069		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5069	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) JOHN LITRONE		
2. DATE AND HOUR OF DEATH 5-23-67			3A. M. 3A		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL BALTIMORE, MD			A. STATE MARYLAND B. COUNTY BALTIMORE CO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 33-00		
D. STREET ADDRESS (If rural, give location) 362 ROCKDALE TERRACE					
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 4/4/00	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION AUTO SERVICE		11. BIRTHPLACE (State or foreign country) New Oxford, PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Joseph TRONE		14. MOTHER'S MAIDEN NAME ZARTMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 216-01-6973		17. INFORMANT KATHRYN S. TRONE - SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Acute myocardial infarction 5-23-67 (B) Arteriosclerotic Heart disease 1955 (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none					
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (I APPROX.) none		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> none		21F. HOW DID INJURY OCCUR? none	
22. I certify that (I) (this hospital) attended the deceased from Jan 1, 1955 19 to May 23 19 67 , that (I) (we) last saw the deceased alive on 5-23-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Milton E. Lowman M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5-23-67	
23C. PHYSICIAN'S NAME (Type) MILTON E. LOWMAN M.D.				23D. ADDRESS 4843 Park Heights Ave Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-26-67		24C. NAME OF CEMETERY FOR CREMATORY NT Cemetery	
24D. LOCATION (City, town, or county) (State) Littlestown, Pennsylvania					
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR Robert E. Fawcett		25C. FUNERAL DIRECTOR ELSWORTH ARMACOST ADDRESS 4600 Liberty Heights	

THE ...
...
...

...
...
...

...
...
...

...
...
...

...
...
...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 5070	
BIRTH NO. 67 5070		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHNSON, MR. PAGAN		2. DATE AND HOUR OF DEATH 5-23-67 5:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 11-02			
				D. STREET ADDRESS (If rural, give location) 808 St. Paul (Midtown Nursing Home)			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 5-11-27-1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LUKE JOHNSON				14. MOTHER'S MAIDEN NAME CLARA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 7-1-18 7-19-19				16. SOCIAL SECURITY NO. 239-601272		17. INFORMANT CLEOPATRO CHERRY	
18. 15 IX I				CAUSE OF DEATH		ADDRESS 1639 N. BROADWAY	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) PNEUMONITIS AND TERMINAL PUL. EDEMA		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES				(B) HEPATIC INSUFFICIENCY DUE TO MASSIVE LIVER METASTASES		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) CARCINOMA OF THE ANTRAL PORTION OF THE STOMACH		?	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 5-6-1967 to 5-23-1967 , that (2) (we) last saw the deceased alive on 5-23-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE William T. Mason				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-23-67	
23C. PHYSICIAN'S NAME (Type) WILLIAM T. MASON				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-27-67		24C. NAME of CEMETERY or CREMATORY CARYER MEMORIAL		24D. LOCATION (City, town, or county) (State) LAUREL Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR JOSEPH E. GARDNER		25C. FUNERAL DIRECTOR JOSEPH KNIGHT		ADDRESS 1639 N. BROADWAY	

PAGE 2

WATSON ROAD

BALTIMORE

BOB W. JONES

RECEIVED 21 OCT 1981

M D

Persons are advised to return

to the station
in the morning
to the water tower
and to return
to the station
to return

YES

YES

WATSON T. JONES

WATSON T. JONES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5071		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5071	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 5/23/67 4:05 A.M.	
1. NAME OF DECEASED (Type or Print) SQUIRE S		BABY BOY			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital		A. STATE Maryland		B. COUNTY 603	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 23 N. Collington Avenue			
5. SEX MALE	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5/21/67	9. AGE (in years last birthday) 2	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME GORDON SQUIRES		14. MOTHER'S MAIDEN NAME ELIZABETH HORNEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS Gordon Squires 23 N. Collington Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) RESPIRATORY & HEART FAILURES (B) Bilateral hy drothorax (C)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/19/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/21/67 to 5/23/67 that (I) (we) last saw the deceased alive on 5/23/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Baltazar Jr. M.D.		23B. DATE SIGNED 5/23/67			
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR, JR. M.D.		23D. ADDRESS CHURCH HOME & HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-24-1967		24C. NAME of CEMETERY or CREMATORY Mt. Carmel	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.	

Chances of survival

of the patient

2/21/67

MADE WHITE

very good

1.50

ELISA BETH

Donson 2011

11/10/67

20

RESPIRATORY
HALL
BIOLOGICAL and CHEMICAL

2/21/67

20

1

FRANCIS BARTON, JR.
Framingham

11/10/67

11/10/67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5072	
BIRTH NO. 67 5072		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Maurice Martin Swartz		2. DATE AND HOUR OF DEATH 5/24/1967 9²⁵ A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY 5-06			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 1607 NORTH DURHAM STREET	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 3-5-90	9. AGE (in years last birthday) 77	10. CITIZEN OF WHAT COUNTRY?		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY H. J. Dryer Box Factory		11. BIRTHPLACE (State or foreign country) Harrisburg, Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME EMANUEL SWARTZ				14. MOTHER'S MAIDEN NAME ANGELA MAGNESS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-03-4510		17. INFORMANT ADDRESS Mrs. Mildred Swartz 1607 N. Durham Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest (?) Myocardial Infarction (?) 1 night				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
21A. DATE OF OPERATION 2		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 5/24 19 67 to 5/24 19 67 , that (we) last saw the deceased alive on 5/24 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE Stephen W. Spaulding				23B. DATE SIGNED 5/24/67			
23C. PHYSICIAN'S NAME (Type) STEPHEN W. SPAULDING		23D. ADDRESS JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-27-1967		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR ADDRESS Gilly & Zeiler Inc. 1901-07 Eastern Ave.			

Handwritten text at the top of the page, possibly a title or header, including the word "Mammals".

London Area (?)

Myosotis (Mammals?)

Handwritten notes and a signature at the bottom of the page. The signature appears to be "J. H. ...".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

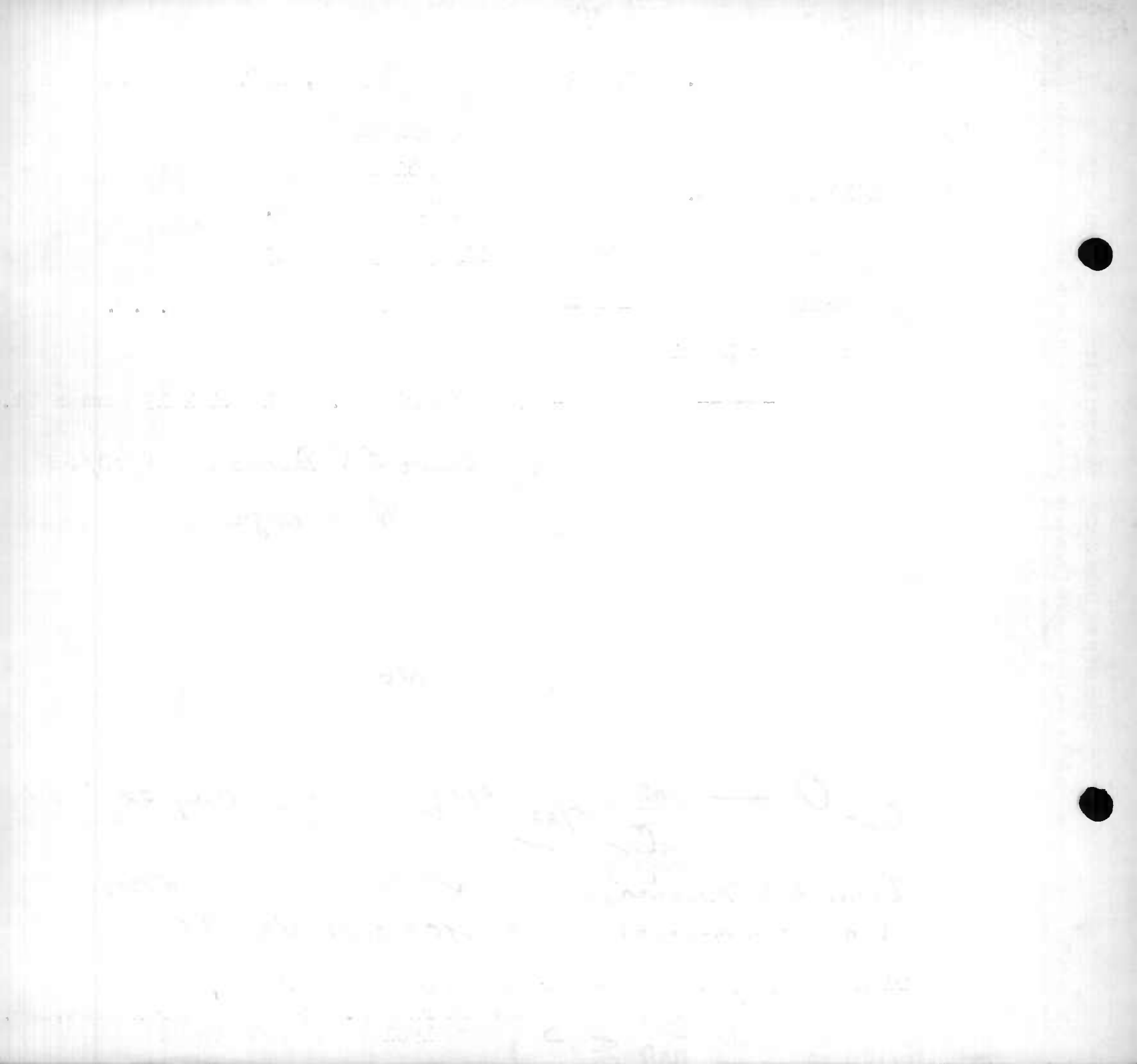
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5073	
BIRTH NO. 67 5073		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Peter J. Sharlofsky, Sr. (Sharlofski)		2. DATE AND HOUR OF DEATH May 22, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1420 Hull St.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 24-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1420 Hull St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 11, 1904		9. AGE (In years lost birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Sharlofsky				14. MOTHER'S MAIDEN NAME Sofia Yaipovna			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-1678		17. INFORMANT ADDRESS Margaret V. Sharlofsky 1420 Hull St.			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Acute Coronary Occlusion DUE TO (B) PREVIOUS MYOCARDIAL INFARCTION DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH MINUTS YEARS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 9 1965 to MAY 20 1967 , that (I) (we) last saw the deceased alive on MAY 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Luis J. Elias M.D. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5/24/67			
23C. PHYSICIAN'S NAME (Type) Luis J. Elias, M.D.		23D. ADDRESS M.D. 1701 Meridene Drive Balto. 12, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/25/67		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR D. E. F.		25C. FUNERAL DIRECTOR ADDRESS Charles D. Stevens Funeral Home, Inc. 1501 East Fort Avenue			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5074		REGISTERED NO. 67 5074	
1. NAME OF DECEASED (Type or Print) Joseph J. Godleski				2. DATE AND HOUR OF DEATH May 22, 1967 2:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1413 Lowman St.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 24-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1413 Lowman St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/8/1903	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman			10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Godleski				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-03-4896		17. INFORMANT ADDRESS Catherine D. Godleski 1413 Lowman St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 443X1 Hypertensive C.V. Disease Cerebral Hemorrhage				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH 8/13/63	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) N/C		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 8/23 19 63 to May 22 19 67 , that (1) (we) last saw the deceased alive on 5/22 19 67 and that (1) (my) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Vincent M. Messina				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/24/67	
23C. PHYSICIAN'S NAME (Type) Vincent M. Messina				23D. ADDRESS M.D. 1403 S. Charles St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/26/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR W. E. Godleski		25C. FUNERAL DIRECTOR Charles L. Stevens		ADDRESS 1501 East Fort Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 5075 CAESAR					CERTIFICATE OF DEATH					Registered No. 67 5075				
1. NAME OF DECEASED (Type or Print) <i>Caesar, Blanche</i>					2. DATE AND HOUR OF DEATH <i>5/23/67 1:00 A. M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-01</i>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>DuKeland Nursing Home - 1501 DuKeland St.</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>									
D. STREET ADDRESS (If rural, give location) <i>1373 H. Stricker Street</i>														
5. SEX <i>F</i>		6. RACE <i>N</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>2-8-87</i>		9. AGE (In years lost birthday) <i>80</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				
										12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <i>DuKeland Nursing Home</i> ADDRESS <i>1501 DuKeland</i>				
18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <i>Hypertensive CV Disease</i> DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>2-21-1967</i> to <i>5-23-1967</i> , that (I) (we) last saw the deceased alive on <i>5-22-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>Perceval C. Smith</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>5-23-67</i>				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS <i>1709 Gwynns Falls Pkwy</i> M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>			24B. DATE <i>5-27-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cem.</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>						
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 25 1967</i>					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>					25C. FUNERAL DIRECTOR <i>George A. Kline</i> ADDRESS <i>1348 H. Ellen St.</i>				

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

VANESSA A. WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

5-23-67

3:01 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

824 Seagull Avenue 21225

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
never married

8. DATE OF BIRTH

9-19-58

9. AGE (In years
last birthday)

8

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Elroy Williams

14. MOTHER'S MAIDEN NAME

Janet Hebb

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
none

17. INFORMANT

ADDRESS

Elroy Williams 824 Seagull Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Drowning
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Pond

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Behind incinerator

8000 Block Reedbird Avenue 25-32

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 23 '67 2:25 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell in pond while
trying to catch a turtle

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-24-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-27-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

Arbutus

Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 25 1967

24B. NAME OF REGISTRAR

Robert S. Fisher

24C. FUNERAL DIRECTOR

Kelson Funeral Home

ADDRESS

1348 Calhoun St.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIE MAE JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

5-24-67

8:35 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1851 N. COLLINGTON AVENUE - Amb. Crew #3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1851 N. Collington Avenue 21213

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

3/3/07

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter Chase

14. MOTHER'S MAIDEN NAME

Mary Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Family

18.

422.15260X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DISEASE

associated with diabetes mellitus

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-24-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/27/67

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cem

23D. LOCATION

(City, town, or county)

(State)

A.A. Co. Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 25 1967

R. S. Fisher, M.D.

R. S. Fisher, M.D. 1701-N Bond St 21213

L-500

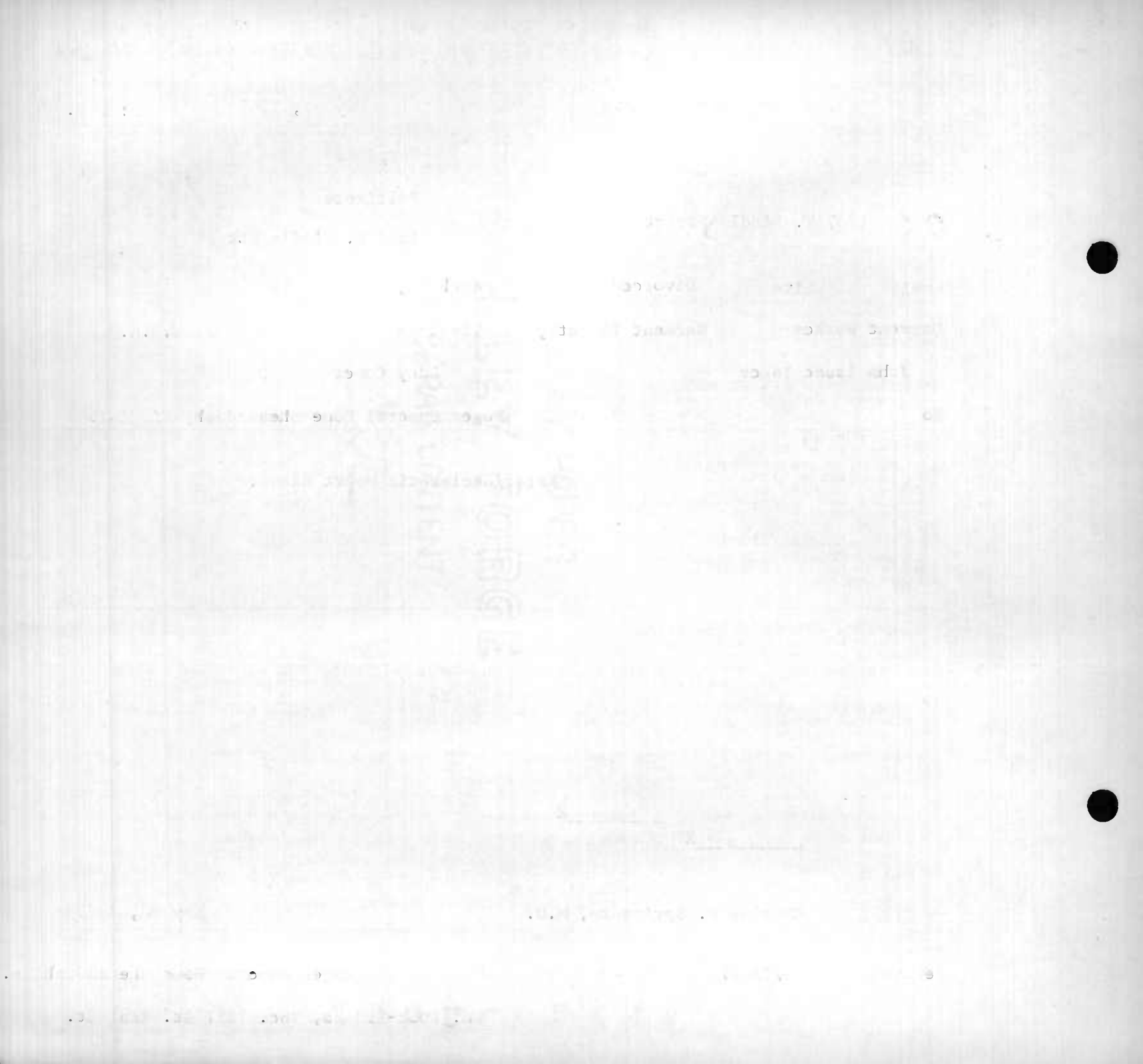
BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5078

M.E. CASE NO.

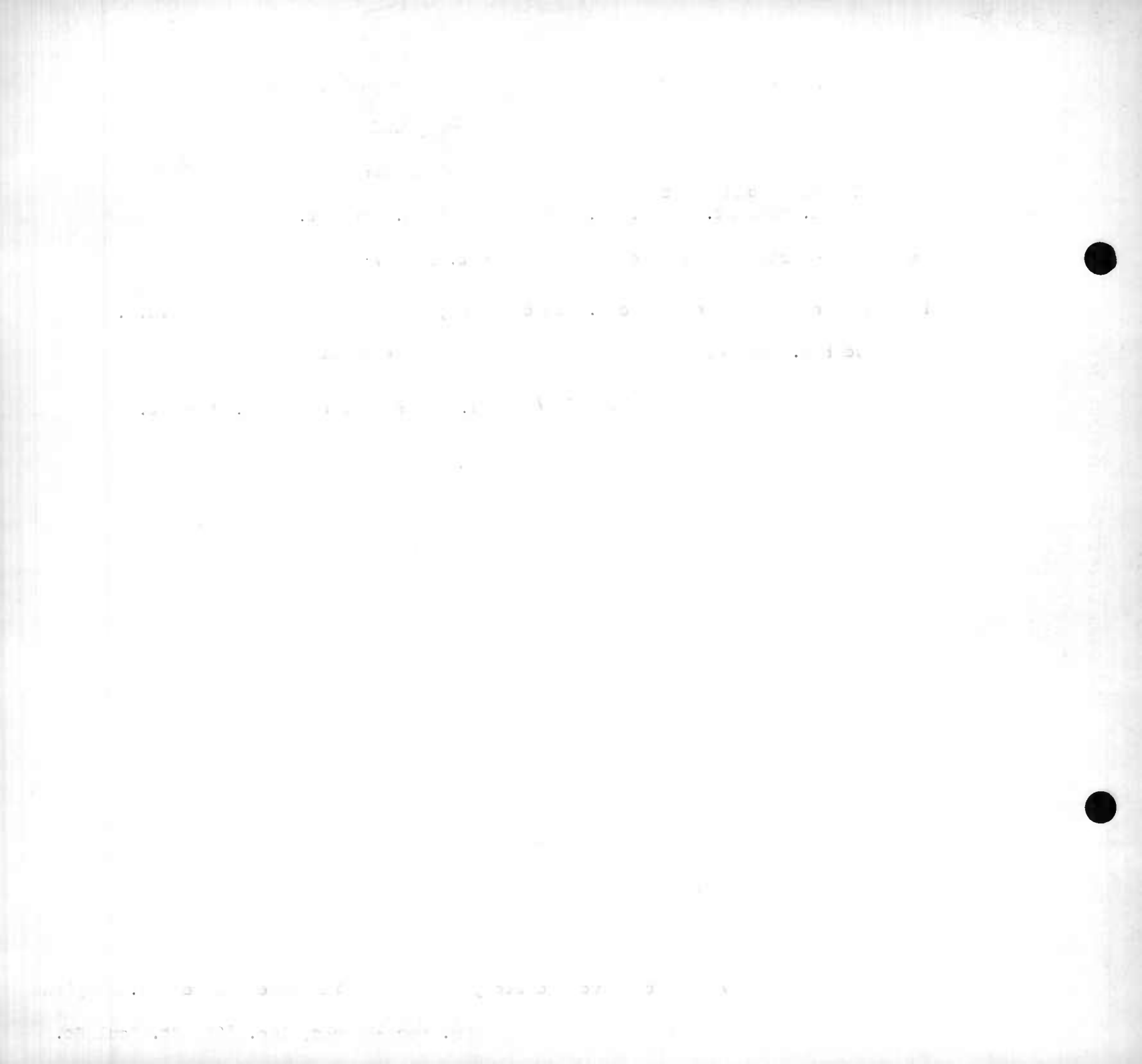
1. NAME OF DECEASED (Type or Print)		VIRGINIA LANE		2. DATE AND HOUR PRONOUNCED DEAD May 24, 1967 5:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland	
00 1207 E. Biddle Street				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01	
				D. STREET ADDRESS (If rural, give location) 1207 E. Biddle Street	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH March 30, 1901	9. AGE (In years last birthday) 66	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garment Worker		10B. KIND OF BUSINESS OR INDUSTRY Garment Industry		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Issac Yager			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. ?		
17. INFORMANT Kuger Funeral Home Shenandoah, Virginia			ADDRESS		

MEDICAL CERTIFICATION	18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease					
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
	19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
	21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
	21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	21F. HOW DID INJURY OCCUR?					
	22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
	ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED May 25, 1967	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 5/25/67		23C. NAME of CEMETERY or CREMATORY Resthaven Cemetery		
24A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		24B. NAME OF REGISTRAR R. J. 162 700-0		24C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc. 1217 St. Paul St.		
		24D. LOCATION (City, town, or county) (State) Kuger Funeral Home Shenandoah, Va.				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5079	
BIRTH NO. 67 5079		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THOMAS HENRY ARMIGER		2. DATE AND HOUR OF DEATH MAY 22, 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Midtown Nursing Home 808 St. Paul St. Balto. Md. 21202				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 316 N. Paca St.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH Sept. 3, 1878	9. AGE (In years last birthday) 88	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10B. KIND OF BUSINESS OR INDUSTRY Retail Dept. Store		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Armiger				14. MOTHER'S MAIDEN NAME Maggie Trott			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-3791		17. INFORMANT ADDRESS Mrs. Elsie Armiger 316 N. Paca St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory Failure Massive Myocardial Infarction Arteriosclerotic CVA Gen. Arteriosclerosis Sclerosis				INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 19 1967 to May 22 1967 , that (I) (we) lost saw the deceased alive on May 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William D. Appleford				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/25/67	
23C. PHYSICIAN'S NAME (Type) William D. Appleford		23D. ADDRESS M.D. 5501 Park Heights Dr.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/26/67		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Anne Arundel Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 25 1967		25B. NAME OF REGISTRAR Wm. Cook-Brooks, Inc.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5080				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5080	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print) EDITH MARGARET BILSON				MAY 23, 1967		1:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE MARYLAND B. COUNTY			
36 FRANKLIN SQUARE HOSP.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 4707 SAYER AVE.			
5. SEX F		6. RACE N		7. MARRIED-NEVER MARRIED WIDOWED- N DIVORCED (specify)		8. DATE OF BIRTH 11/29/88	
9. AGE (In years lost birthday) 78		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DANIEL STAUP		14. MOTHER'S MAIDEN NAME CORDELIA BYERLY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-54-4400		17. INFORMANT MARIE COCKRAN		ADDRESS 4707 SAYER AVE, 29		18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CIA	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		20. DUE TO DEHYDRATION & ELECTROLYTE IMBALANCE		21. INTERVAL BETWEEN ONSET AND DEATH		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
23. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		24. DATE OF OPERATION 0		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) ✓	
27. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		28. DATE OF OPERATION 0		29. CONDITION FOR WHICH OPERATION WAS PERFORMED		30. AUTOPSY? (Yes or No) ✓	
31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		34. DATE OF INJURY (Month) (Day) (Year) (Hour)	
35. TIME OF INJURY (APPROX.)		36. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		37. HOW DID INJURY OCCUR?		38. I certify that (I) (this hospital) attended the deceased from 5/16 19 67 to 5/23 19 67 , that (I) (we) last saw the deceased alive on 5/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
39. SIGNATURE Inclauzo		40. M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		41. DATE SIGNED 5/23/67		42. PHYSICIAN'S NAME (Type) MILAGROSA R. CALIZO	
43. ADDRESS FRANKLIN SQ. HOSP.		44. DATE REC'D BY HEALTH DEPT. MAY 26 1967		45. NAME OF REGISTRAR John J. Tolan		46. FUNERAL DIRECTOR Wm. J. Dickerson	
47. ADDRESS Baltimore, Md.		48. BURIAL CREMATION, REMOVAL (Specify) Burial		49. DATE 5/25/1967		50. CEMETERY OR CREMATORY Woodlawn Cemetery	
51. LOCATION (City, town, or county) (State) Woodlawn, Md.		52. DATE REC'D BY HEALTH DEPT. MAY 26 1967		53. NAME OF REGISTRAR John J. Tolan		54. FUNERAL DIRECTOR Wm. J. Dickerson	
55. ADDRESS Baltimore, Md.		56. DATE REC'D BY HEALTH DEPT. MAY 26 1967		57. NAME OF REGISTRAR John J. Tolan		58. FUNERAL DIRECTOR Wm. J. Dickerson	
59. ADDRESS Baltimore, Md.		60. DATE REC'D BY HEALTH DEPT. MAY 26 1967		61. NAME OF REGISTRAR John J. Tolan		62. FUNERAL DIRECTOR Wm. J. Dickerson	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5081	
BIRTH NO. 67 5081		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Thiele		2. DATE AND HOUR OF DEATH May 22, 1967 11:50 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Bolton Hill Nursing Center FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-07			
		D. STREET ADDRESS (If rural, give location) 64 N Culver St.			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) Never Married	8. DATE OF BIRTH 9-24-94	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Short Order Cook		10B. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Franz Thiele		14. MOTHER'S MAIDEN NAME Helma Weber	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 215-14-4263-A		17. INFORMANT ADDRESS Records: Bolton Hill Nursing Center 1400 John St., Balto., Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH BRONCHOGENIC CARCINOMA		INTERVAL BETWEEN ONSET AND DEATH			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/22/67 19 to 5/22/67 19 that (I) (we) last saw the deceased alive on 5/22/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Annis Tennant				23B. DATE SIGNED 5/22/67	
23C. PHYSICIAN'S NAME (Type) Annis Tennant		23D. ADDRESS 930 WHITELOCK ST. BALTIMORE MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/25/1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Wm. F. Tichner		25C. FUNERAL DIRECTOR Wm. F. Tichner & Sons	

2000-2001

$$x = \frac{1}{2}$$

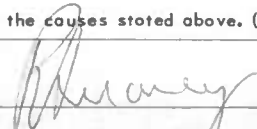
7/2/2

~~5/2/2~~

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5083	
BIRTH NO. 67 5083		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MC KEEVER JOSEPH		MAY 24 1967 8:20 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville D. STREET ADDRESS (If rural, give location) 333 HARLEM LANE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 1-28-94	9. AGE (In years lost birthday) 73	10. Under 1 Yr. Months Days 10. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JOCKEY AND TRAINER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.Y.	
13. FATHER'S NAME WILLIAM McKeever DEC'D			14. MOTHER'S MAIDEN NAME ANNE MC LAUGHLIN DEC'D		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 01 9360		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS	
18. 241X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Brachial Asthma DUE TO (B) Longestine Heart failure DUE TO (C) Associated Large Basal Abst. etiology unknown		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 23 19 67 to MAY 24 19 67 , that (I) (we) last saw the deceased alive on MAY 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 5-24-67	
23C. PHYSICIAN'S NAME (Type) RAMON SUAREZ		23D. ADDRESS CATON AND WILKENS AVE. BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/26/1967		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Wm. J. Tichner		25C. FUNERAL DIRECTOR Wm. J. Tichner & Sons with J.P.A.	

CO:1

SECRET

100-100000

SECRET

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 140 67 5084		CERTIFICATE OF DEATH				Registered No. 67 5084			
1. NAME OF DECEASED (Type or Print) SHIPLEY, RALPH B.					2. DATE AND HOUR OF DEATH 5-23-67 5:45 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY FREDERICK Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) FREDERICK 60-11 D. STREET ADDRESS (If rural, give location) 1411 PINewood DR.				
5. SEX M	6. RACE CAUC.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-12-27	9. AGE (In years lost birthday) 40	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE PARTS		11. BIRTHPLACE (State or foreign country) FREDERICK, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Emory B. Shipley-Sr.			14. MOTHER'S MAIDEN NAME Helen L. Mulligan						
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWAR 11			16. SOCIAL SECURITY NO. 220-26-5682		17. INFORMANT 1411 Pinewood Dr. Mrs. Elizabeth E. Shipley-Frederick-Md.				
18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO CARDIAC ARREST (B) DUE TO PROBABLE PULM. EMBOLISM OR MYOCARDIAL INFARCT (C) LYMPHO SARCOMA			INTERVAL BETWEEN ONSET AND DEATH 30 MIN. 1 DAY 8 WKS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 4-26-67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LYMPHOSARCOMA		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 4-11 19 67 to 5-23 19 67, that (I) (we) last saw the deceased alive on 5-23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Shiao-Chiu Andrew Chen M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-23-67		
23C. PHYSICIAN'S NAME (Type) SHIAO-CHIU ANDREW CHEN M.D.					23D. ADDRESS JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 25-1967		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Frederick, Md. 21701			
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR M. D. Johnson & Son-Frederick, Md. 21701		ADDRESS 1411 Pinewood Dr. Frederick, Md.			

158 82 554
AT 11:11 - 11:11

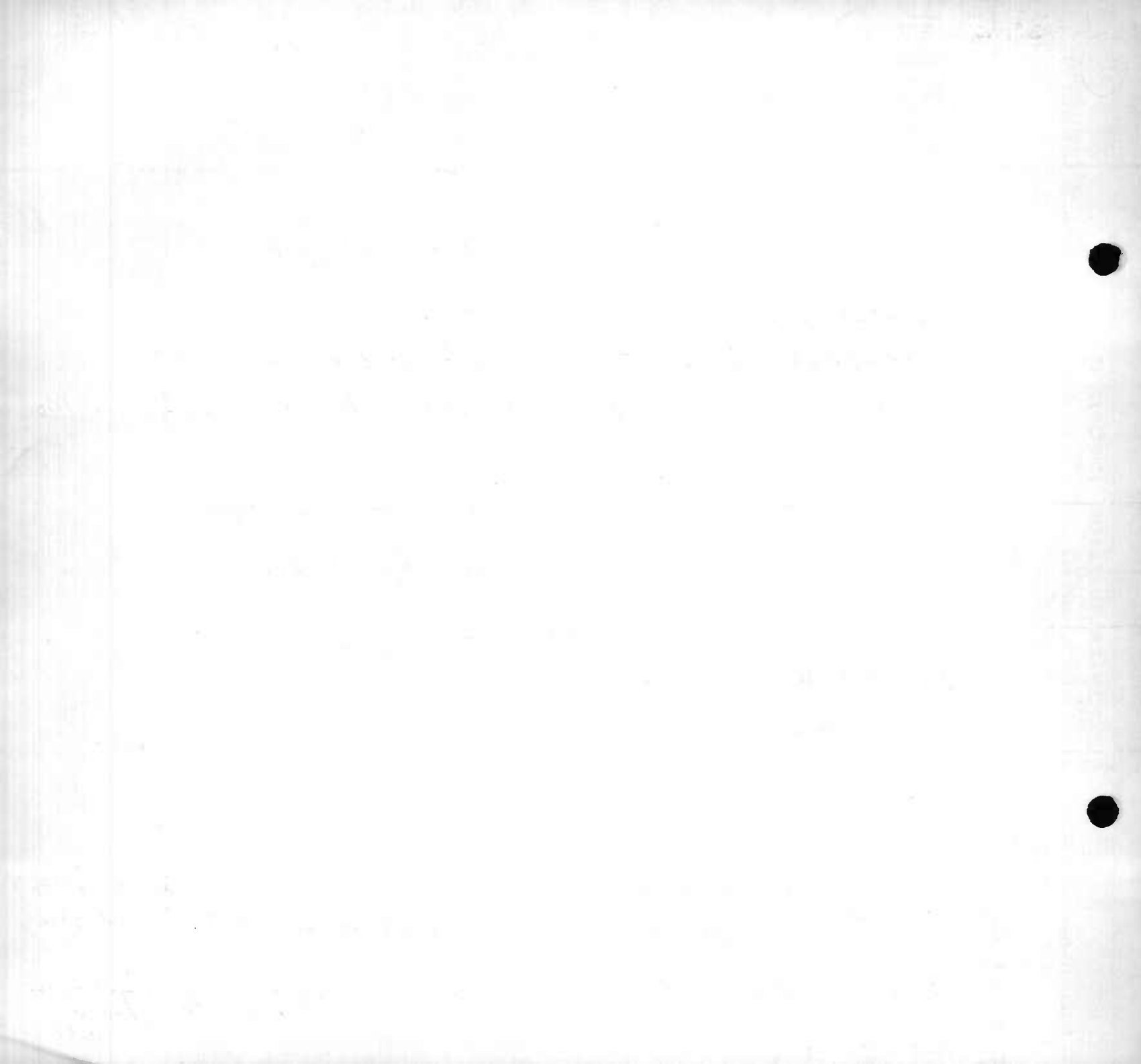
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV, 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 32-99-75	
BIRTH NO. 67 5086						67 5086	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Littleton, Joshua A.				2. DATE AND HOUR OF DEATH 10/16 5/18/67 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hosp. 38		(If not in hospital or institution, give street address or location)		A. STATE R# 3		B. COUNTY Wicomico Co.	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Delmar, Maryland 72-00			
				D. STREET ADDRESS (If rural, give location) Route # 3			
5. SEX Male	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-27-13	9. AGE (in years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POULTRYMAN			11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME GEORGE LITTLETON			14. MOTHER'S MAIDEN NAME DEBBIE LITTLETON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 222-10-5085		17. INFORMANT ADDRESS GLADYS M. LITTLETON, Delmar Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 421.1 I				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Pneumonia			
ANTECEDENT CAUSES				(B) DUE TO Aortic stenosis (Past)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Aortic Prosthesis			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION May 6 to 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Poor		20A. AUTOPSY? (Yes or No) ✓		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Zouheir Shama M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 18 to 1967	
23C. PHYSICIAN'S NAME (Type) ZOUHEIR SHAMA				23D. ADDRESS M.D. University Hospital, Baltimore, Md. 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-21-67		24C. NAME of CEMETERY or CREMATORY Bethel Mariners Cem.		24D. LOCATION (City, town, or county) (State) Delmar View, Delaware	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS A. Douglas Nelson, Norfolk Del.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

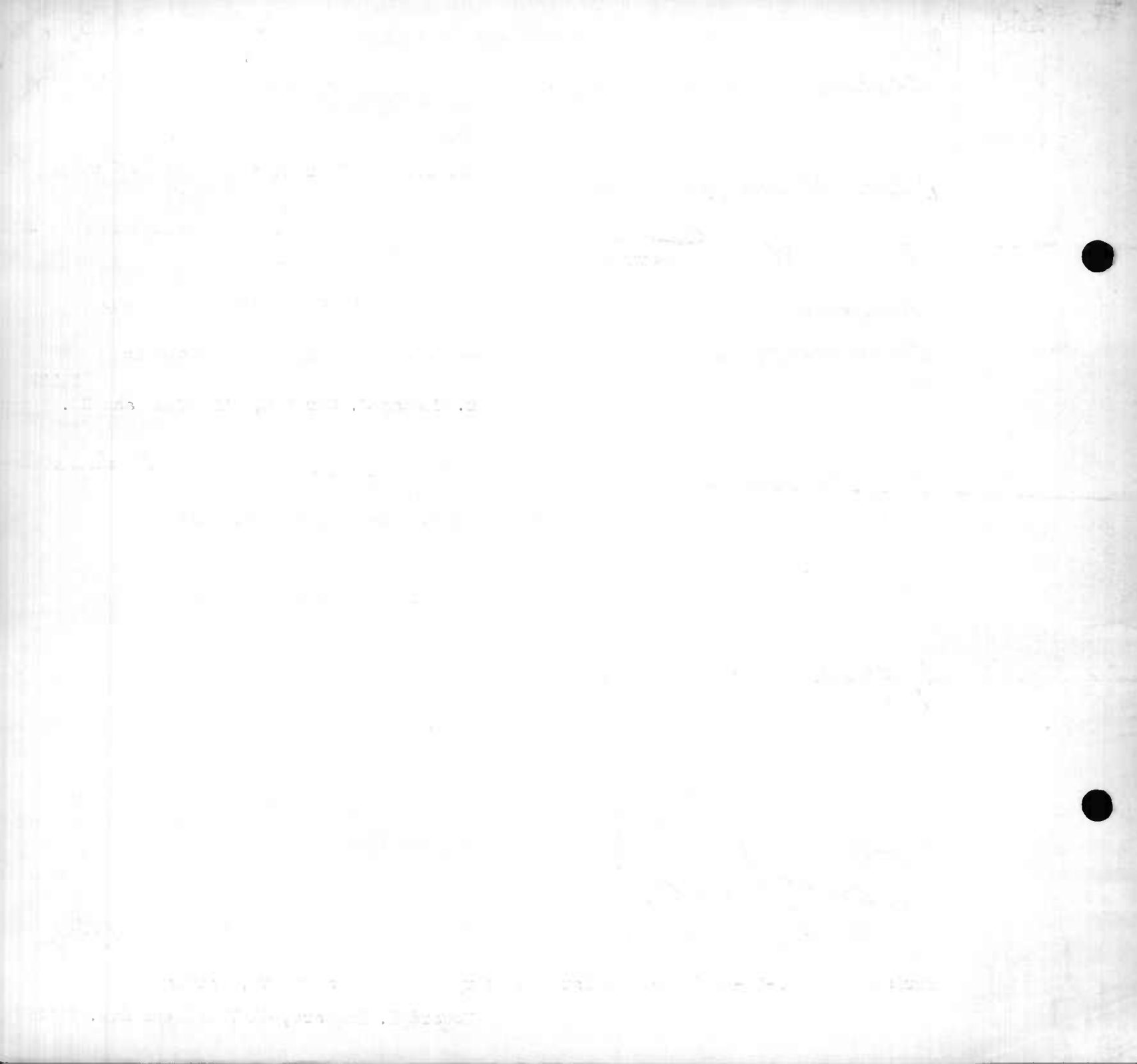
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 67 5087		Registered No. 67 5087							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Elmer Clifford Doughty				2. DATE AND HOUR OF DEATH May 24, 1967 9: 15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Park Drive						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Va. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Oyster D. STREET ADDRESS (If rural, give location) V-43			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower		8. DATE OF BIRTH 6/28/04	9. AGE (In years lost birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deckhand		11. BIRTHPLACE (State or foreign country) Va.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deckhand		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William Doughty				14. MOTHER'S MAIDEN NAME Amanda Outten					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 227-24-1877		17. INFORMANT ADDRESS Records- US P HS Hospital, Balto, Md.			
18. CAUSE OF DEATH									
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Chronic lymphocytic leukemia				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Years			
18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) DUE TO					
				(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Apr. 21 19 67 to May 24 19 67, that (I) (we) last saw the deceased alive on May 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Michael E. Pelczar M.D.						23B. DATE SIGNED 5/24/67			
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surg (R)				23D. ADDRESS M.D. US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/26/67		24C. NAME of CEMETERY or CREMATORY Cape Charles Cemetery		24D. LOCATION (City, town, or county) (State) Cape Charles, Virginia			
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR A. D. H. H. H.		25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave.			

Michael E. Peterson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

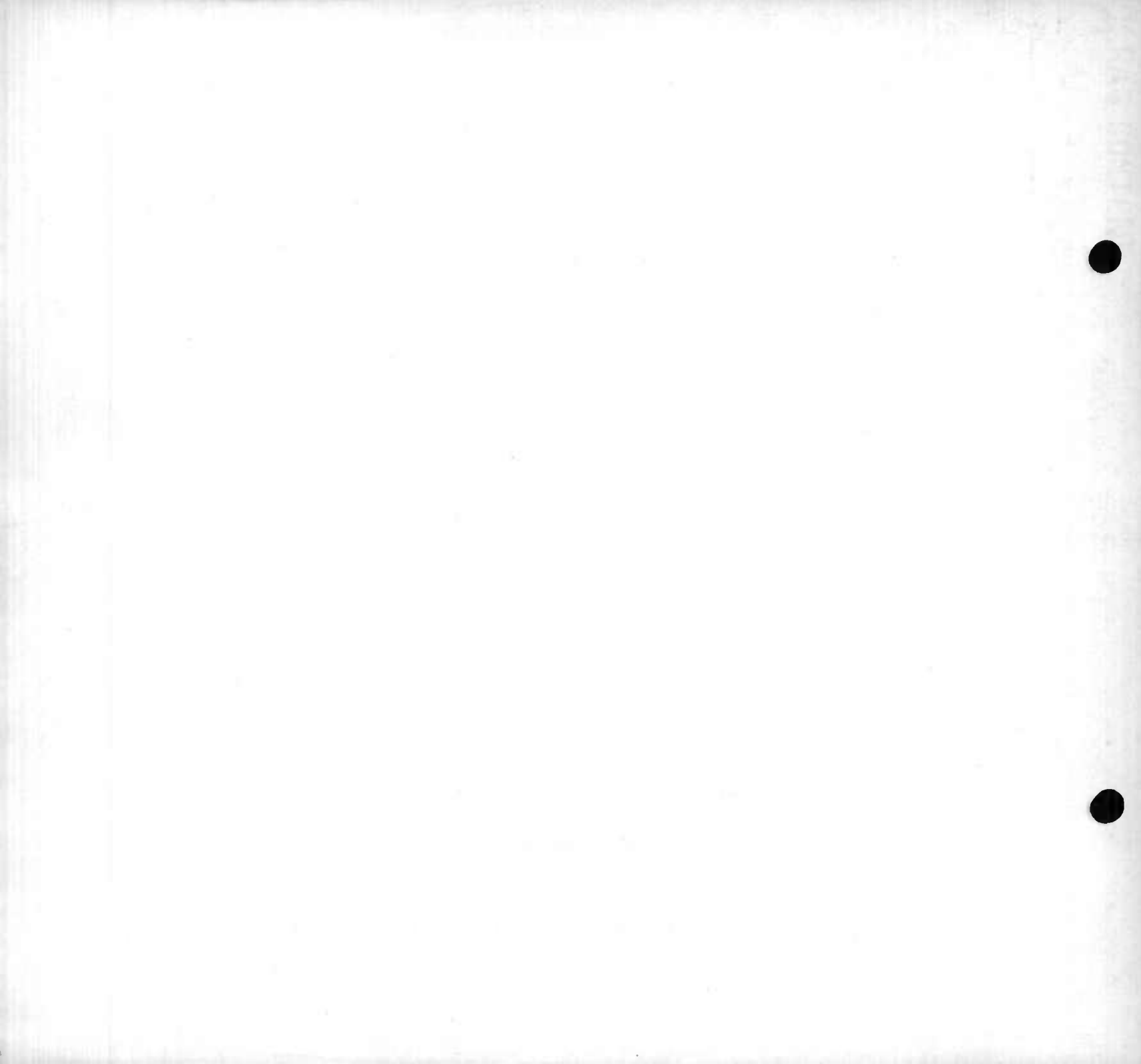
BIRTH NO. 67 5088		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5088	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) CORNINE, CATHERINE CLAIRE			2. DATE AND HOUR OF DEATH 5/23/67 12 15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIV. OF MD. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY Balto. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) XXXXXXXXXX Arbutus D. STREET ADDRESS (If rural, give location) 1231 TENOAKS RD.		
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/11/07	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MASS Massachusetts	
13. FATHER'S NAME DULAK, MATTHEW			14. MOTHER'S MAIDEN NAME XXXXXXXXXX ANTOINETTE Velonic		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) 0		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Thomas J. Cornine, 1231 Ten Oaks Rd. 21227	
18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MITRAL VALVE REPLACEMENT & TRICUSPID VALVE PLICATION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RHEUMATIC VALVULAR DISEASE			INTERVAL BETWEEN ONSET AND DEATH 5 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/18/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RHEUMATIC VALVULAR DIS.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date _____ and hour _____ and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Howard H. Hubbard				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Howard H. Hubbard				23D. ADDRESS UNIV. of Maryland Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-26-1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5089	
BIRTH NO. 67 5089		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Marian Lynch Bellis</u>		2. DATE AND HOUR OF DEATH <u>May 24, 1967 1:30 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore City</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>001603 Burnwood Rd.</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>1603 Burnwood Rd.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED <u>Married</u> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>Dec. 26 1896</u>	9. AGE (In years lost birthday) <u>70</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William C. Lynch</u>			14. MOTHER'S MAIDEN NAME <u>Jeanette Brooks</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-24-9691</u>		17. INFORMANT <u>George A. Bellis</u>		ADDRESS <u>Same</u>	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		CAUSE OF DEATH (A) DUE TO <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours - 5 years</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Osteoporosis severe</u>		(B) DUE TO		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Osteoporosis severe</u>		<u>1 year</u>			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 7</u> 19 <u>55</u> to <u>May 24</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 24</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A.S. Chalfant</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>May 25, 67</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. S. Chalfant</u>				23D. ADDRESS <u>6210 York Rd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 26, 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 26 1967</u>		25B. NAME OF REGISTRAR <u>R. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>		ADDRESS <u>by apm Burgee Hones</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5090	
BIRTH NO. 67 5090		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) GRACE I. GREEN			2. DATE AND HOUR OF DEATH MAY 23 '67 8⁰⁵ P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSP			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4225 FLOWERTON Rd.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 2/12/94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOCHSCHILD KOHN - RETIRED SALES		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME NICHOLAS GREEN		
14. MOTHER'S MAIDEN NAME KATE SANKE			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO		
16. SOCIAL SECURITY NO. 214-03-4512			17. INFORMANT GERALDINE PEAKE ADDRESS 6120 BURNT OAK RD.		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest		CAUSE OF DEATH (A) DUE TO Myocardial infarction (B) DUE TO Atherosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH MINUTES 24 hours UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>this hospital</u> attended the deceased from 5/22 19 67 to 5/23 19 67 , that (I) <u>we</u> last saw the deceased alive on 5/23 19 67 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE Timothy K. Gray M.D.				23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) TIMOTHY KENNEY GRAY M.D.				23D. ADDRESS MARYLAND GENERAL HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/26/67		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967			
25B. NAME OF REGISTRAR R. L. McFarland		25C. FUNERAL DIRECTOR ST. STANSBURY ADDRESS BALTO. MD.			

1/14

REMARKS

4552 Fawcett Rd

1/14/99

123

1/14

1st 2nd

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

1/14

1/14

1/14

+

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

1/14

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

1/14

1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67-32811
W-480
BIRTH NO. 5091

Registered No. 67 5091

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM CHARLES WHEELER

2. DATE AND HOUR PRONOUNCED DEAD

5-24-67

9:00 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

(Dundalk)

D. STREET ADDRESS (If rural, give locofan)

987 Dalton Avenue 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov. 24/ 1962

9. AGE (In years
last birthday)

4

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Md..

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William C. Wheeler, Sr.

14. MOTHER'S MAIDEN NAME

Jane E. Saunders

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

////////////////

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mr. Wm. C. Wheeler, Sr. (father) same as #2

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Carbon monoxide poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) conflagration
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1st floor living room at 987
Dalton Avenue21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 24 '67 8:40 AM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

House fire

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-24-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

May 26, 1967

23C. NAME of CEMETERY or CREMATORY

Glen Haven Mem. Park

23D. LOCATION

(City, town, or county)

Glen Burnie, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 26 1967

24B. NAME OF REGISTRAR

R. S. Fisher

24C. FUNERAL DIRECTOR

R. S. Singleton

Singleton Funeral Home
Glen Burnie, Md.

[Handwritten signature]

64-02211

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **67 5092** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 5092**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) **KELYE LYNN WHEELER** 2. DATE AND HOUR PRONOUNCED DEAD
5-24-67 9:00 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland** B. COUNTY **Baltimore Co.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore (Dundalk) 53-00

D. STREET ADDRESS (If rural, give location)

987 Dalton Avenue 21224

5. SEX

Female

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Single**

8. DATE OF BIRTH

Jan. 16, 19649. AGE (In years
last birthday)**3**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.12. CITIZEN OF
WHAT COUNTRY?**U.S.A.**

13. FATHER'S NAME

William C. Wheeler, Sr.

14. MOTHER'S MAIDEN NAME

Jane E. Saunders15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**no**16. SOCIAL
SECURITY NO.**none**

17. INFORMANT

ADDRESS

Mr. Wm. C. Wheeler, Sr. (Father) Same As #4

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Carbon monoxide poisoning**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) **conflagration**
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)**Home**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**Front room - 2nd floor of
987 Dalton Avenue**21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 24 '67 8:40 AM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

House fire

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)**RUSSELL S. FISHER, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-24-6723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

May 26, 1967

23C. NAME of CEMETERY or CREMATORY

Glen Haven Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 26 1967

24B. NAME OF REGISTRAR

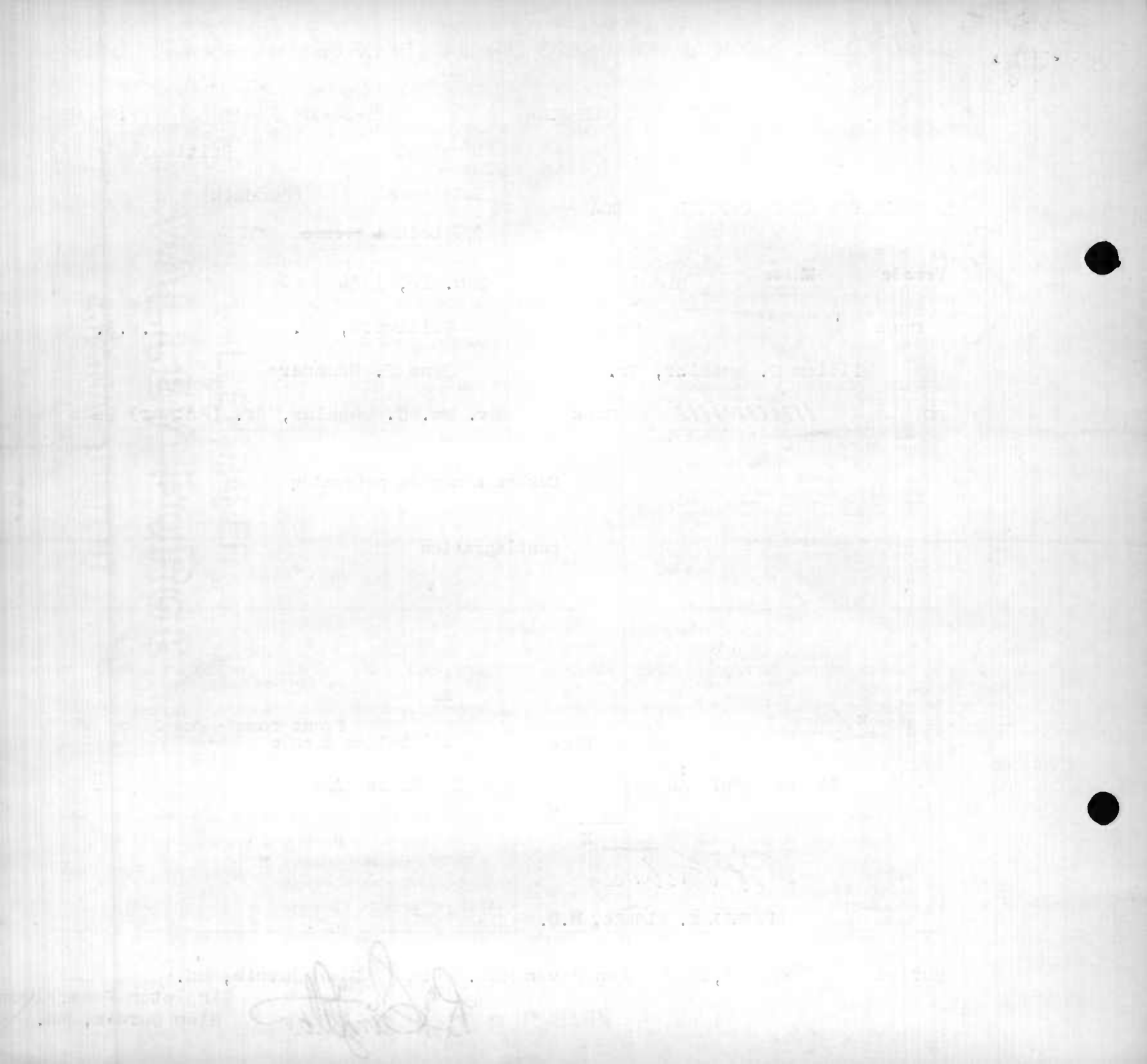
Robert E. Talama

24C. FUNERAL DIRECTOR

Singleton Funeral Home

ADDRESS

Glen Burnie, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. 67 5093	
BIRTH NO. 67 5093		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HERION, ANNIE	
2. DATE AND HOUR OF DEATH 5-23-67 12:40 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BOLTON HILL NURSING CENTER			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 3005 LAVENDER AVE #34 B. COUNTY Baltimore Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Co.			
D. STREET ADDRESS (If rural, give location) 53-00					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-6-85	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Baltimore, Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN SCHNIEDER			
14. MOTHER'S MAIDEN NAME Katherine Neihardt		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-05-9935		17. INFORMANT ADDRESS Mrs Marie Nichles 3005 Lavender Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/23/67 to 5/23/67 that (I) (we) last saw the deceased alive on 5/23/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) ANNIE SCHNIEDER		23D. ADDRESS 930 CONIFERWOOD ST, BALT, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-26-1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Co.		24E. STATE Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS 2401 Belair Rd	

2102-10-11

2/20/11

2/20/11

2/20/11

2/20/11

✓

Handwritten signature and text, possibly "Handwritten Signature" and "Handwritten Text".

Handwritten text, possibly "Handwritten Text" and "Handwritten Text".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
H-431 67 5094					CERTIFICATE OF DEATH					Registered No. 67 5094									
BIRTH NO. M.E. CASE NO.										1. NAME OF DECEASED									
(Type or Print)										HELL DORFER, MRS. PEARL B.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										2. DATE AND HOUR OF DEATH									
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
35 CHURCH HOME & HOSP.										A. STATE MD. B. COUNTY Balto. Co.									
5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed										C. CITY OR TOWN (If outside city limits, write RURAL and give township)									
										BALT. 53-00									
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										D. STREET ADDRESS (If rural, give location)									
Ret, Cafeteria Manager Baltimore Co. Educ. MD. Baltimore Co.										RT. 16, BOX 114(20)									
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME									
WILLIAM BIDDISON										ELARA SCHULTZ									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.									
No										218-22-9837									
17. INFORMANT										ADDRESS									
CHURCH HOME & HOSP.																			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH									
(This does not mean the mode of dying, e.g., heart failure, oshtemo, etc. It means the disease, injury or complication which caused death.)										INTERVAL BETWEEN ONSET AND DEATH									
ANTECEDENT CAUSES																			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
II																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20A. AUTOPSY? (Yes or No)										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)										21E. INJURY OCCURRED									
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 5/22 1967 to 5/23 1967, that (I) (we) last saw the deceased alive on 5/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE										23B. DATE SIGNED									
Rodolfo M. Lim M.D.										5-23-67									
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS									
Rodolfo M. Lim M.D.										CHH									
24A. BURIAL CREMATION, REMOVAL (Specify)										24B. DATE									
Burial										5-27-1967									
24C. NAME OF CEMETERY OR CREMATORY										24D. LOCATION (City, town, or county) (State)									
Parkwood Cemetery										Baltimore, Md									
25A. DATE REC'D BY HEALTH DEPT.										25B. NAME OF REGISTRAR									
MAY 26 1967										J. J. J. J.									
25C. FUNERAL DIRECTOR										ADDRESS									
Baltimore Funeral Home										2401 Adam Road (36)									

(08) 111 21 11

11 11 11 11

11 11 11 11

11 11 11 11

11 11 11 11

11 11 11 11

11 11 11 11

11 11 11 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

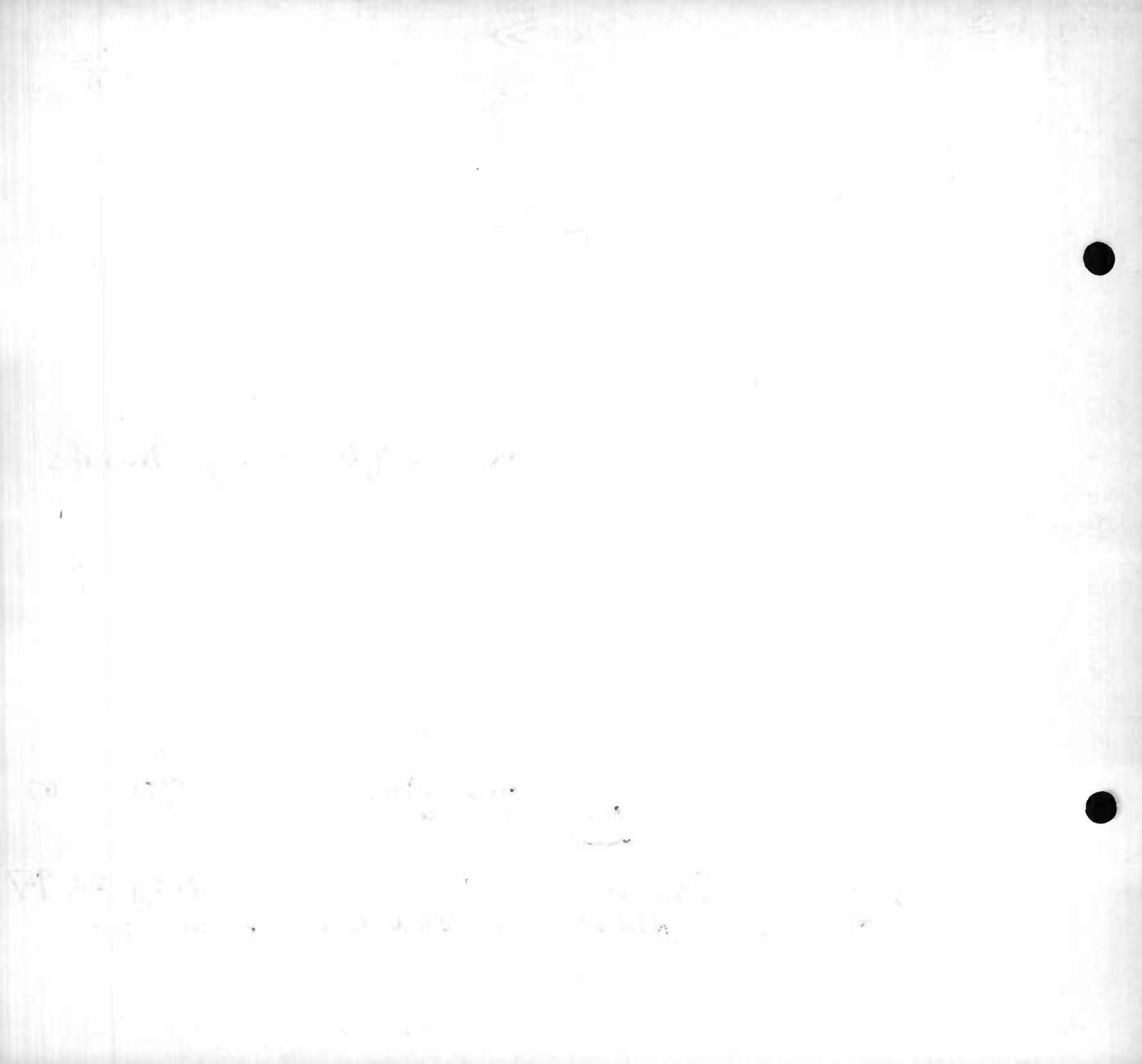
BIRTH NO. 67 5095		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5095	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ROSA NICOLETTE		2. DATE AND HOUR OF DEATH 5-23-67 10:20 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE DUNDALK 53-00 D. STREET ADDRESS (If rural, give location) 230 PATAPSCO AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-20-88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME JAMES VINCENT			14. MOTHER'S MAIDEN NAME SOPHIA (?)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214/54/5034		17. INFORMANT ADDRESS JOHN NICOLETTE - AS IN #4	
18. 433,11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Ventricular fibrillation DUE TO		hours.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Pulmonary Edema DUE TO		7 hr.	
		(C) Arteriosclerotic Cardio-vascular disease		year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Uremia, Chronic renal disease		year	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 27 1967 to May 23 1967 , that (I) (we) last saw the deceased alive on May 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. C. MARIANO		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 5-23-67		
23C. PHYSICIAN'S NAME (Type) J. C. MARIANO		23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 5/27/1967	24C. NAME OF CEMETERY OR CREMATORY Union & Faith		24D. LOCATION (City, town, or county) (State) Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967	25B. NAME OF REGISTRAR Robert E. Garbino	25C. FUNERAL DIRECTOR W. B. Brady		ADDRESS W. B. Brady, Dundalk, Md.	

W 4

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5096				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5096	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Moyer Leo James</i>				2. DATE AND HOUR OF DEATH <i>5-21-67 4³⁰ A</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <i>MARYLAND</i>		B. COUNTY	
<i>00508 S. Glover St.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		<i>1-03</i>	
				D. STREET ADDRESS (If rural, give location) <i>508 S. Glover St.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED . NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>4-26-1900</i>	9. AGE (In years lost birthday) <i>67</i>	If Under 1 Yr. Months	If Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Food Fair</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Moyer</i>				14. MOTHER'S MAIDEN NAME <i>MAGGIE StieckFuss</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>212-07-2101</i>		17. INFORMANT <i>MRS. MARTHA Moyer</i>	
				ADDRESS <i>SAME</i>			
18. <i>163X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the lung</i>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Oct. 1964</i> 19 to <i>5/21</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>May 5</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE <i>Gordon Cader</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>May 22, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>GORDON CADER</i>		M.D.		23D. ADDRESS <i>611 Park Ave. - Balto. 21201</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-23-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadow Ridge Mon</i>		24D. LOCATION (City, town, or county) (State) <i>Howard Ct Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 26 1967</i>		25B. NAME OF REGISTRAR <i>John J. ...</i>		25C. FUNERAL DIRECTOR <i>Raymond L. Kaczorowski</i>		ADDRESS <i>2525 Fleet St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5097	
BIRTH NO. 67 5097		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ROBERT M. HUFFINGTON		2. DATE AND HOUR OF DEATH 5-24-67 3:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto Co		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00	
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL Hosp		D. STREET ADDRESS (If rural, give location) 8411 MERRYVIEW DRIVE		11. BIRTHPLACE (State or foreign country) Md	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-29-00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B+O. railway		10B. KIND OF BUSINESS OR INDUSTRY Disp. aut		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALEXANDER HUFFINGTON		14. MOTHER'S MAIDEN NAME MALONE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 705-05-4879		17. INFORMANT Katherine Huffington WIFE		ADDRESS SAME	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CEREBRAL THROMBOSIS DUE TO (B) Dehydration & Hypotension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN ONE WEEK	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I (this hospital) attended the deceased from 5-19 1967 to 5-24 1967, that (I (we) last saw the deceased alive on 5-24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (We) (did) (did not) view the body after death.					
23A. SIGNATURE Timothy K. Gray		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-24-67	
23C. PHYSICIAN'S NAME (Type) TIMOTHY K. GRAY		23D. ADDRESS MARYLAND GENERAL Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-27-67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem	
24D. LOCATION (City, town, or county) Balto Co.		24E. STATE Md		24F. ZIP CODE 21207	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR E. E. E. E.		25C. FUNERAL DIRECTOR Randy Byers	
25D. ADDRESS 8728 L... Rd		25E. CITY, STATE, ZIP CODE Randallstown Md 21133			

Washington

Marriage

John J. General Hoag

340 Maryland Drive

11-21-00

19

12-4

11

Alexander H. H. H. H.

State

Wife

Thomas H. H. H.

Thomas H. H. H.

11-21-00

11-21-00

Thomas H. H. H.

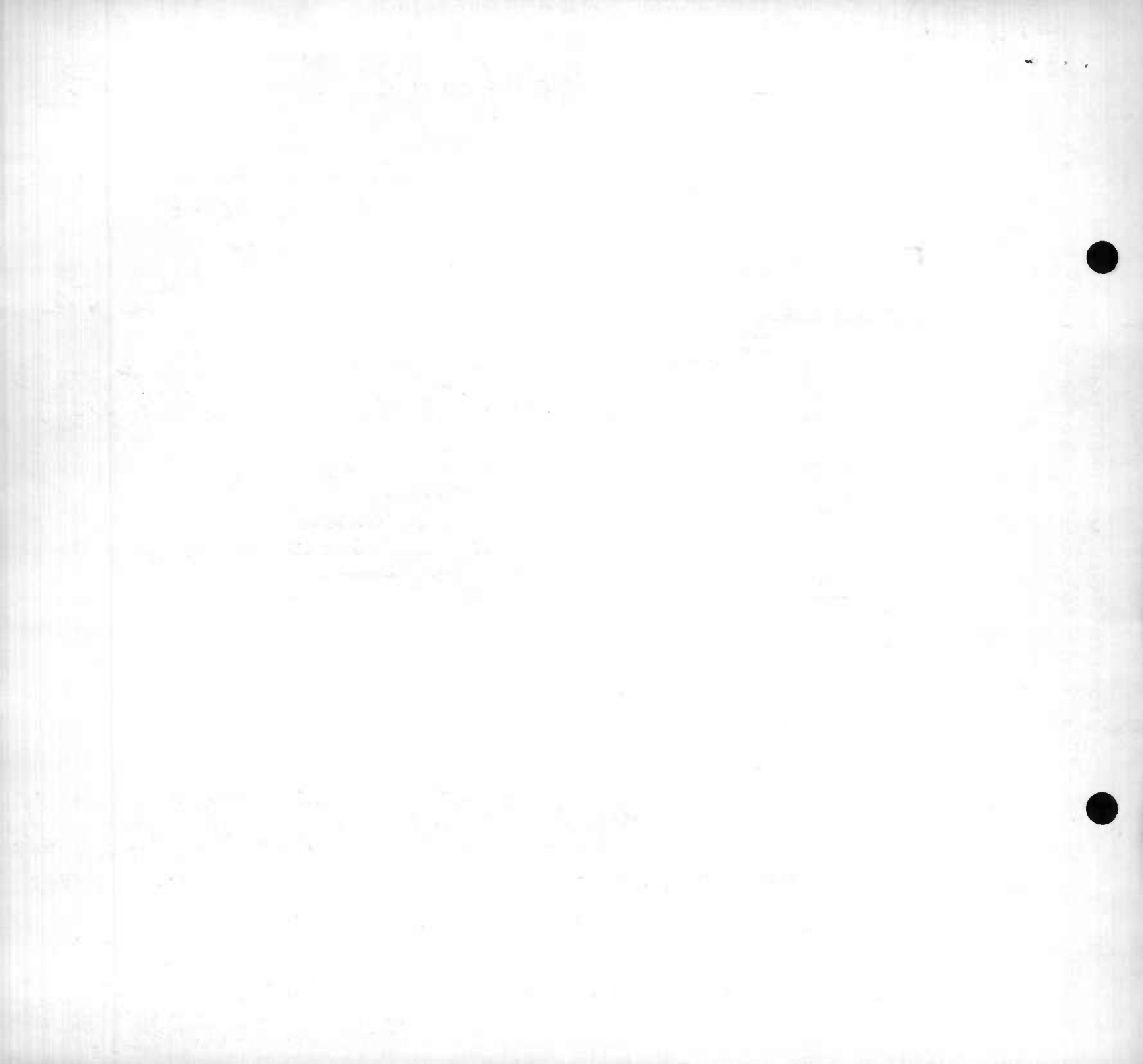
Thomas H. H. H.

Thomas H. H. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
Registered No. 67 5098											
BIRTH NO. 67 5098											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print)		E. IRENE CRAYFORD									
2. DATE AND HOUR OF DEATH		5-23-67 P. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		A. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21215 27-16									
90 Belvedere Ave. Balte		D. STREET ADDRESS (If rural, give location) 4713 Homer Ave.									
5. SEX F	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH Aug 25, 1891	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY				
saleslady		Confectioner		Md			USA				
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
Wm Henry French				Elizabeth Mantz							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
No				22020-0891A		M. Stewart Crawford			3014 Keston Rd. Balte 21207		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH								INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO									
ANTECEDENT CAUSES		(B) DUE TO									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO									
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
0											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from August 1966 to May 23 1967, that (I) (we) last saw the deceased alive on May 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 4:30 PM, May 23, 1967.											
23A. SIGNATURE				23B. DATE SIGNED							
JAMSHID HAMED MD				May 23, 1967							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
JAMSHID HAMED MD				204 E. JOPPA ROAD				TOWSON 4, MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION		24E. FUNERAL DIRECTOR		ADDRESS	
burial		5-26-67		Orand Ridge		Baltimore Md		872 1/2 Liberty Rd		Randallstown Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	
MAY 26 1967		Robert E. Garber		Young Byers		Randallstown Md		211 33			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5099	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) PARTELLO, SABINA C.		2. DATE AND HOUR OF DEATH 5/20/67 9 30 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balt. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) BALTIMORE 1111 Park Ave., APT 201			
5. SEX F	6. RACE Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1/13/08	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY	
EMPLOYEE - CITY OF		BALTO.		United States.	
13. FATHER'S NAME MICHAEL CONLIN			14. MOTHER'S MAIDEN NAME SABINA HOGAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 576-16-7215		17. INFORMANT ADDRESS HOSPITAL CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 593X I		CAUSE OF DEATH Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Electrolyte Imbalance			
		(B) DUE TO Acute Renal Failure			
		(C) Renal Failure			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 18 1967 to May 20 1967 , that (I) (we) lost saw the deceased alive on May 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert Schwarz				23B. DATE SIGNED 5/20/67	
23C. PHYSICIAN'S NAME (Type) HERBERT SCHWARZ		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/23/67		24C. NAME of CEMETERY or CREMATORY ARLINGTON CEMETERY	
24D. LOCATION (City, town, or county) (State) FT. MEYER, VIRGINIA		25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967			
25B. NAME OF REGISTRAR Robert E. Schaefer		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD.			

7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5100</u>	
BIRTH NO. <u>67 5100</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>FANNIE WALSKY</u>		2. DATE AND HOUR OF DEATH <u>MAY 21, 1967</u> <u>6:45 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00</u> <u>824 N. BROADWAY</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>7-05</u> D. STREET ADDRESS (If rural, give location) <u>824 N. BROADWAY</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>OCT. 22, 1889</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>RIGA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FRANK BLOCK</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT ADDRESS <u>MRS. FRIEDA FINK, 2224 PARK AVENUE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4201 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>acute cholecystitis</u>		CAUSE OF DEATH (A) <u>Coronary thrombosis</u> DUE TO (B) <u>A-S-H. D.</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 yr.</u> <u>17 yr.</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <u>Apr. 18</u> 19 <u>50</u> to <u>May 20</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>May 20</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (<u>did</u>) (did not) view the body after death.					
23A. SIGNATURE <u>Norman R. Freeman</u> M.D.				23B. DATE SIGNED <u>5/22/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. NORMAN FREEMAN</u>		23D. ADDRESS <u>11 W. 29th STREET</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/23/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 26 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>			

1891

1892

1893

1894

1895

1896

1897

1898

1899

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

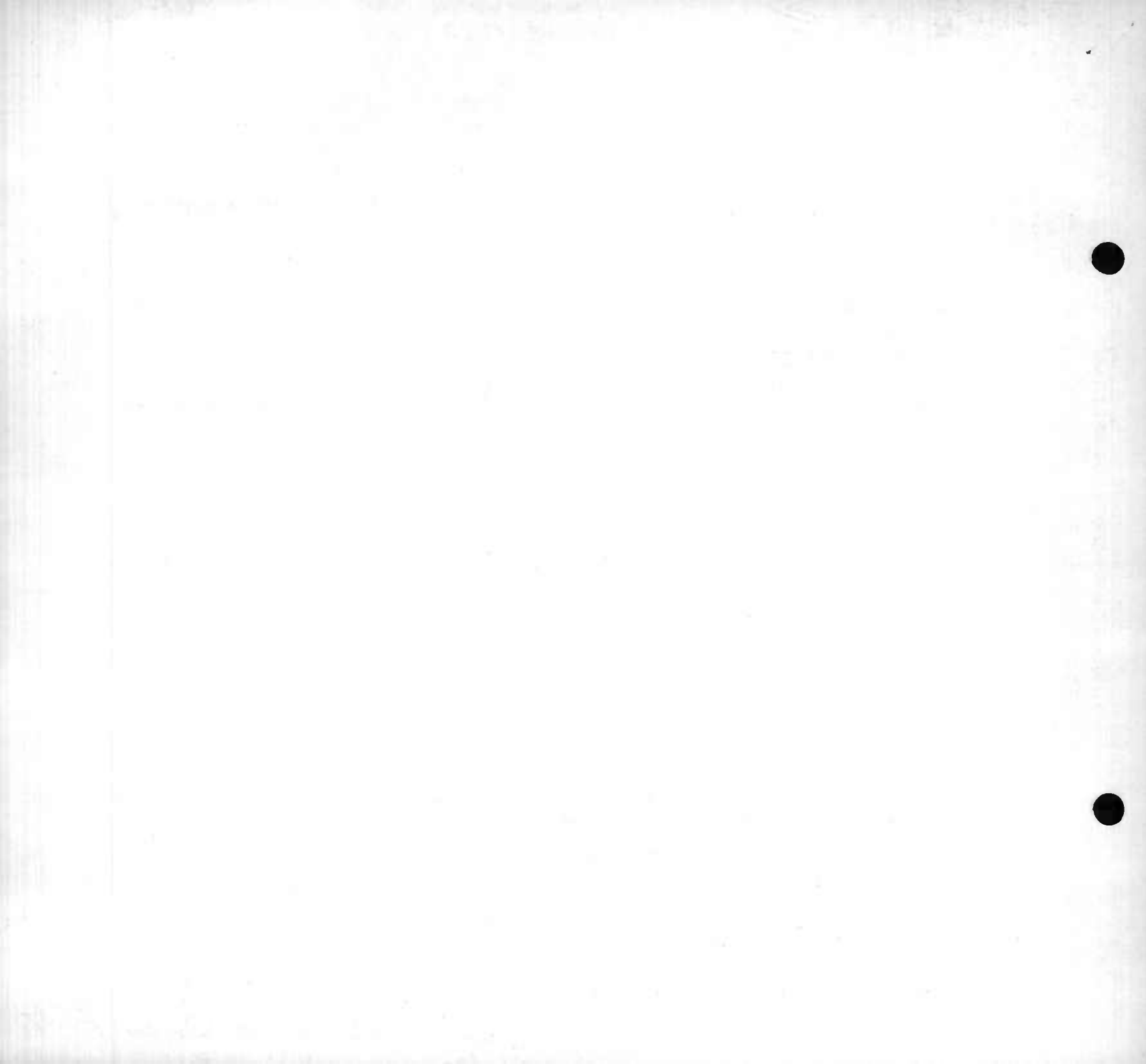
1911

1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

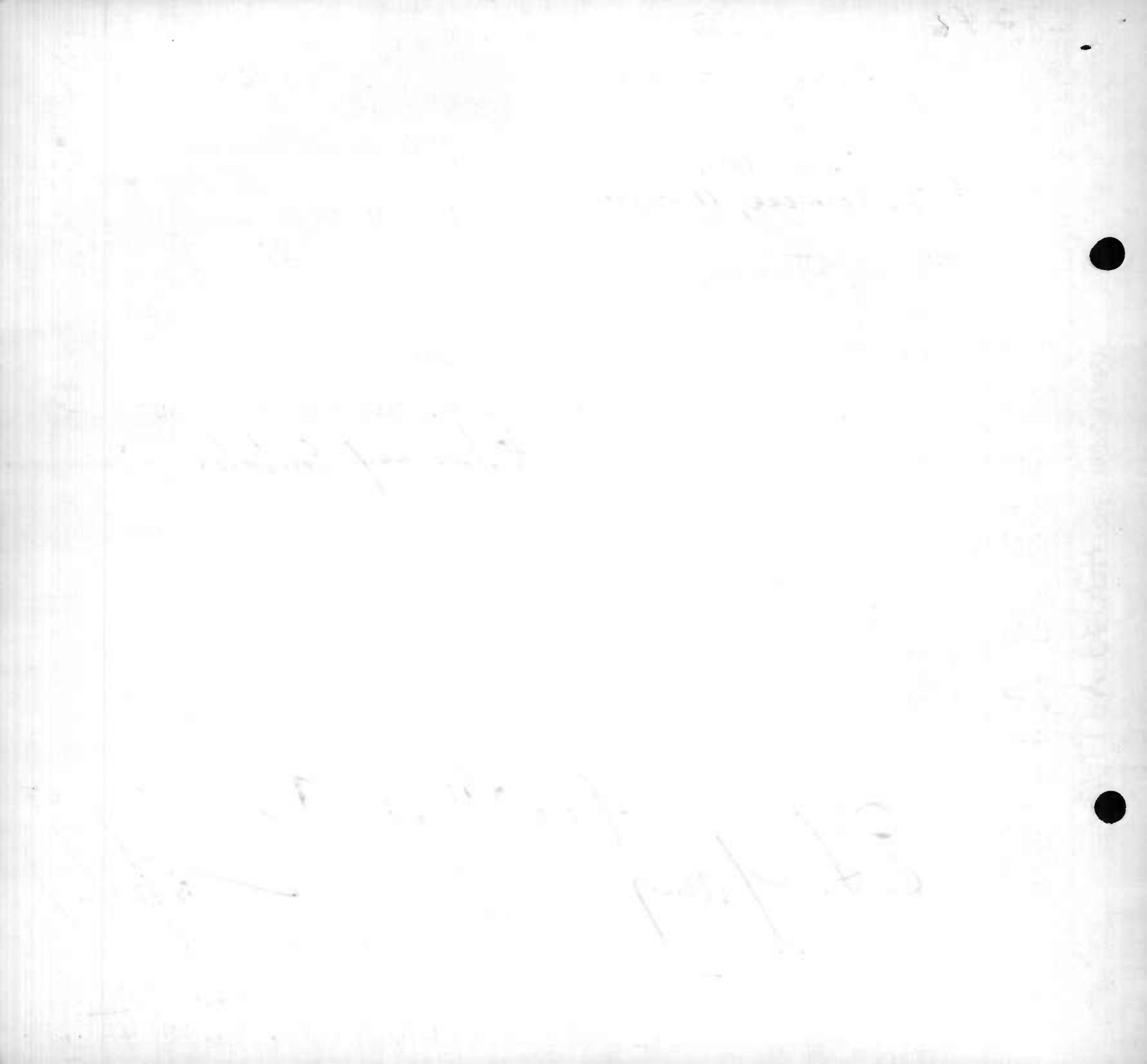
BIRTH NO. 67 5101				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5101	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				(Type or Print) Harry FEINSTEIN		5-23-1967 1:35 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
91		LEVINDALE AGED HOME		Md		Baltimore	
5. SEX				6. RACE			
M				W			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
W				5-3-1893			
9. AGE (In years last birthday)				10. KIND OF BUSINESS OR INDUSTRY			
74				PROPRIETOR			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Poland				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
LOUIS FEINSTEIN				ESTHER MILLER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				UNKNOWN		Nathan Feinstein	
18. CAUSE OF DEATH				ADDRESS		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO		10 minutes	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO		7 yrs	
ANTECEDENT CAUSES				(C) DUE TO		20 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Myocardial Infarction		ASCVD	
Diabetes Mellitus				6939 Brookmill Rd. Baltimore			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from 6-2-66 to 5-23-1967, that (1) (we) lost saw the deceased alive on 5-23-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
1 Ardaiz						5-23-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Jose ARDAIZ				M.D. 5912 Cross Country Blvd. Baltimore, Md. 21215			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		5/24/67		RODIE ZEDEK		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 26 1967		J. C. ZEDEK		J. C. Zeide		F. H.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

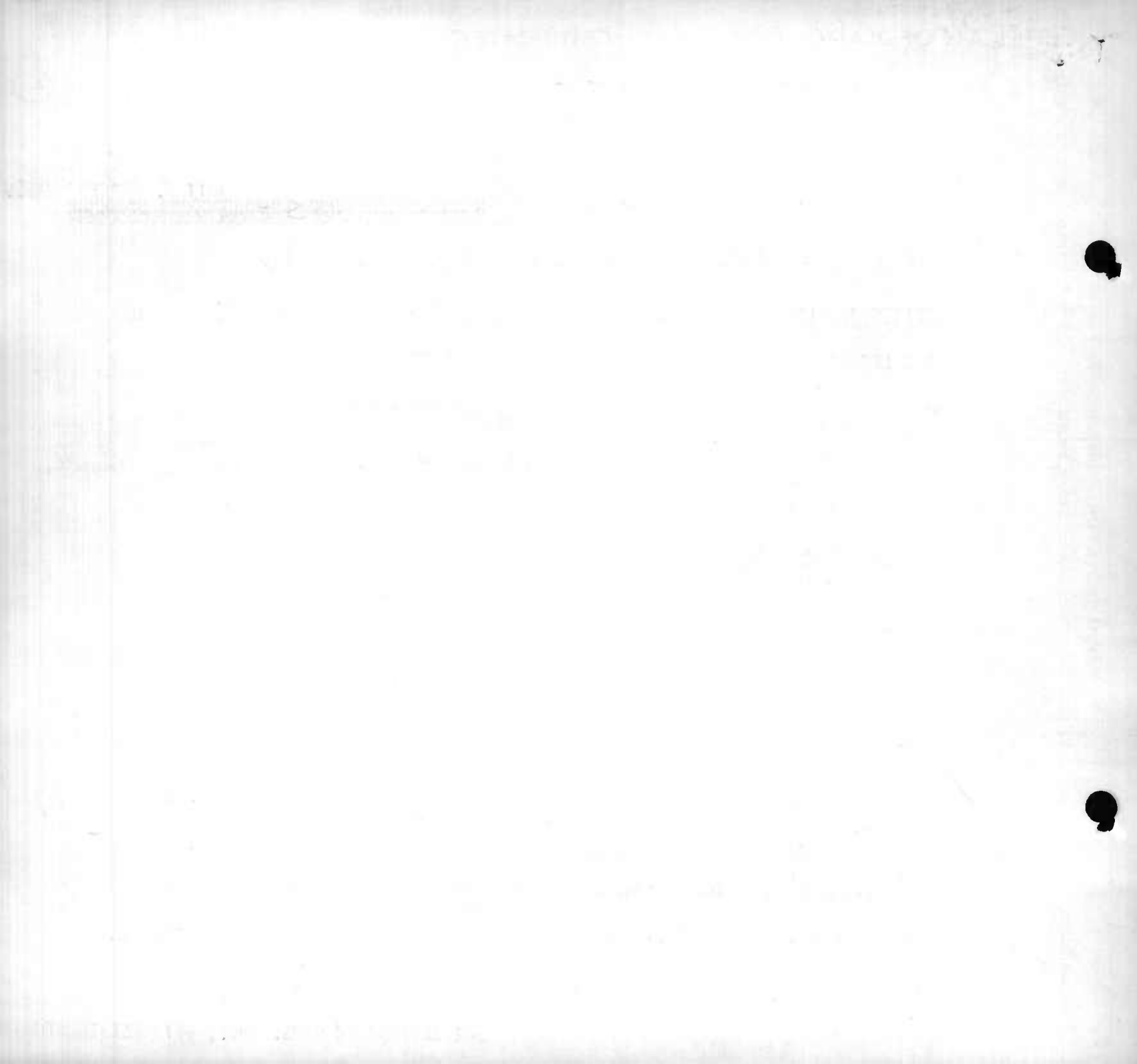
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5102	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5102 M.E. CASE NO. </div>							
1. NAME OF DECEASED (Type or Print) <i>Exler Abraham</i>				2. DATE AND HOUR OF DEATH <i>5/23/67 9:45 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital 42 Baltimore, Maryland</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>3613 BEEHLER AVENUE</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3-6-1886</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>GROCCER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>		11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>UNKNOWN</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>MRS. MOLLIE EXLER 3613 BEEHLER AVENUE</i>			
18. I <i>465X</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <i>Pulmonary Embolus</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>?</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/17/67</i> to <i>5/23/67</i> , that (I) (we) last saw the deceased alive on <i>5/23/67</i> and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R. J. Young</i>				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/23/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>R. J. YOUNG</i>				23D. ADDRESS <i>SINAI HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5/24/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>CIRCLE BOBROISKER BENEFICIAL</i>		24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 26 1967</i>		25B. NAME OF REGISTRAR <i>Edgar E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>501 LEVINSON & BROS. INC., 6010 REIST., RD.</i>			



FUNERAL DIRECTOR: IMPORTANT

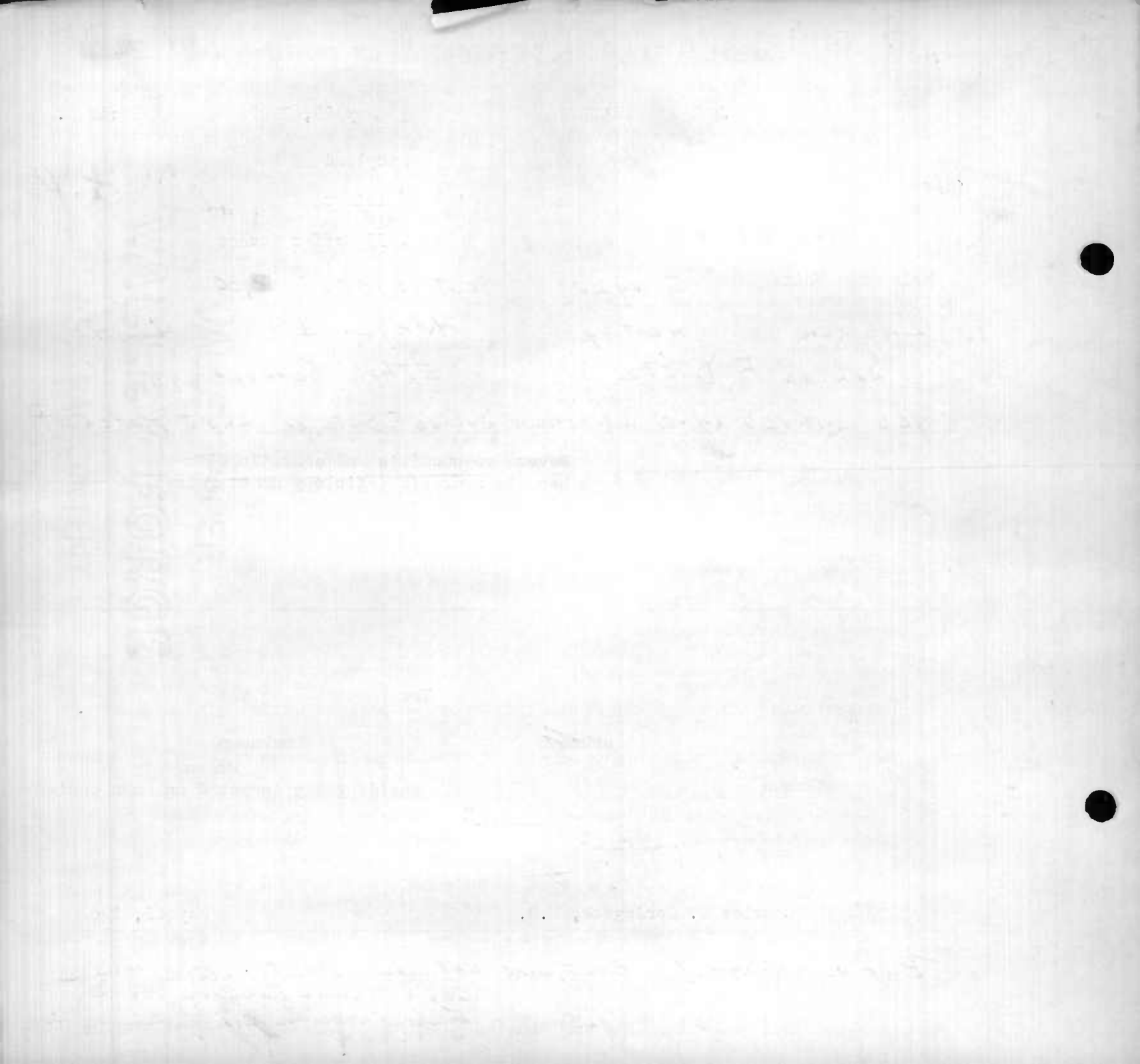
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5103	
BIRTH NO. 67 5103		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ABRAHAM LICHAA		2. DATE AND HOUR OF DEATH 5/23 / 67 1.05 (4M)	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-18 AVE	
		D. STREET ADDRESS (If rural, give location) 4011 W. GARRISON			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12/16/86	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED JEWELRY		10B. KIND OF BUSINESS OR INDUSTRY REPAIR		11. BIRTHPLACE (State or foreign country) EGYPT, CAIRO	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FARG LICHAA		14. MOTHER'S MAIDEN NAME FORTON ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT HOSPITAL CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 293X I ANEMIA of unknown origin		CAUSE OF DEATH (A) DUE TO ORIGEN (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/20 19 67 to 5/23 19 67 , that (I) (we) last saw the deceased alive on 5/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eduardo Hidalgo M.D.				23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO M.D.				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/24/67		24C. NAME of CEMETERY or CREMATORY OHED SHALOM	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		24E. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.		24F. ADDRESS 6010 REISTERSTOWN	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.	



1
D-320

BIRTH NO. 67 5104				BALTIMORE CITY HEALTH DEPARTMENT				67 5104			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.											
1. NAME OF DECEASED (Type or Print) JOHN DIETZ				2. DATE AND HOUR PRONOUNCED DEAD May 25, 1967 12:15 P. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2655 Haffer Street				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-04							
D. STREET ADDRESS (If rural, give location) 2655 Haffer Street											
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH Sept. 10, 1936	9. AGE (In years last birthday) 30	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY HEATING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Julius F. Dietz, Sr.				14. MOTHER'S MAIDEN NAME Ethel Scarborough							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES 2-17-56 to 2-11-58		16. SOCIAL SECURITY NO. 218-32-0030		17. INFORMANT Julius F. Dietz, Sr. 2655 Haffer St.							
I. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe pneumonitis and centrilobular hepatic necrosis (etiology undetermined) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) unknown		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) unknown 00-00							
21D. TIME OF INJURY (APPROX.) unknown		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Presumably accidentally ingested unknown toxin							
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 25, 1967					
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5-29-67		23C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL		23D. LOCATION (City, town, or county) (State) BALTIMORE, Md.					
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR Francis N. Miller		24C. FUNERAL DIRECTOR Geo. L. Schwab							
				ADDRESS 2101 Ludwick Ave.							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

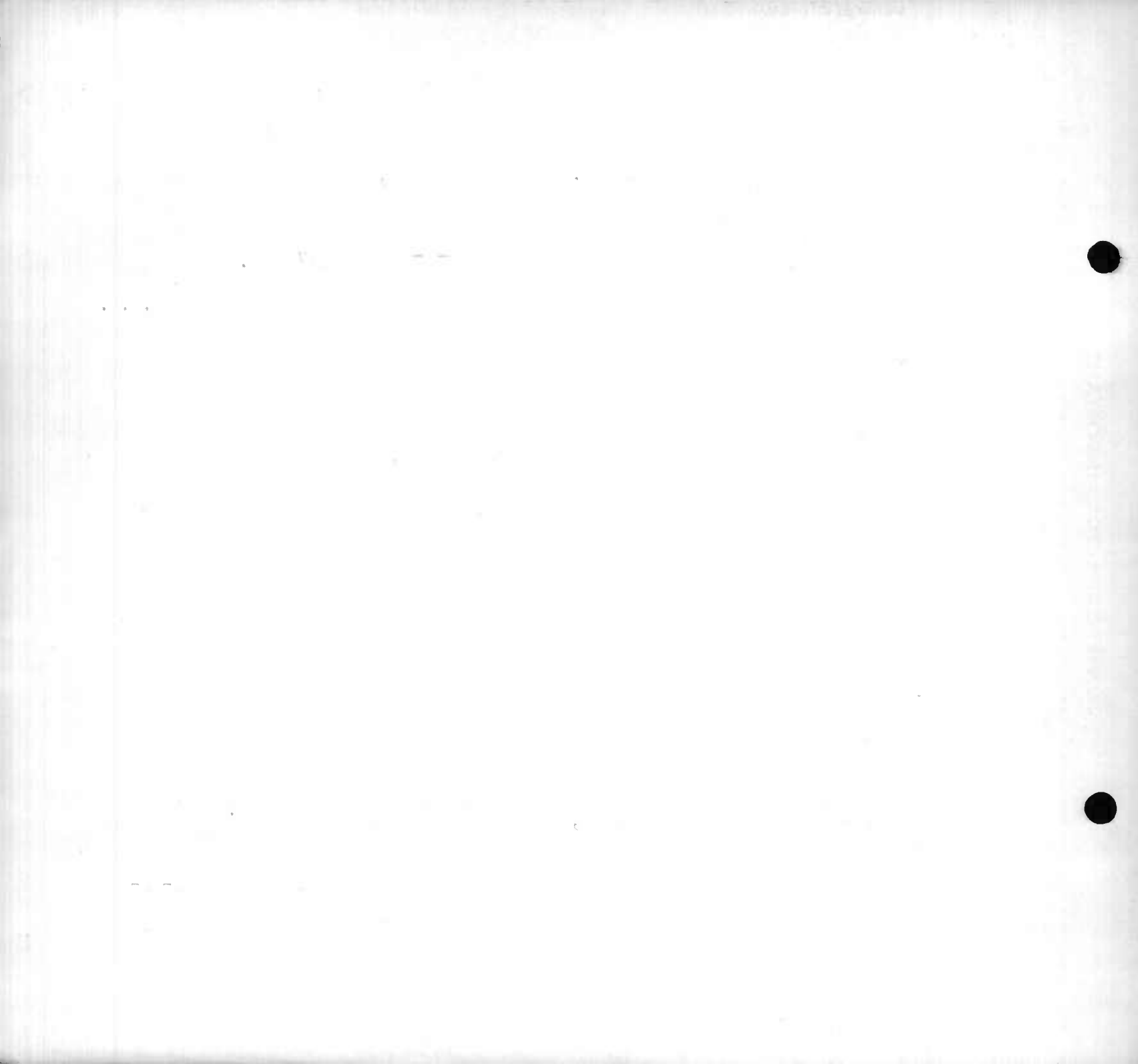
BIRTH NO. 67 5105		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5105	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH 5/22/67 1:20 P.M.	
1. NAME OF DECEASED (Type or Print) CARROLL J. STAFFORD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1810 Edmondson Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1810 Edmondson Avenue			
5. SEX M.	6. RACE N.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-26-1907	9. AGE (In years lost birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ARTHUR STAFFORD			14. MOTHER'S MAIDEN NAME ANNA S. SORRELL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Frances Stafford 1810 Edmondson	
18. 442 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Respiratory failure (B) DUE TO Hemiplegia (C) Arteriosclerotic Cardiovascular renal disease		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to 5/22 19 67 , that (I) (we) last saw the deceased alive on May 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Borofsky M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5/24/67	
23C. PHYSICIAN'S NAME (Type) S BOROFSKY		23D. ADDRESS 601 N. MONROE ST. BALD 17 MD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-27-67		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cem.	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 28 1967		25B. NAME OF REGISTRAR MORTON & DYETT F.H.		25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5106		CERTIFICATE OF DEATH		67 5106	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Julia Johnson		May 22, 1967 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore,			
		D. STREET ADDRESS (If rural, give location)		1500 Pennsylvania	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 12-2-19	9. AGE (In years last birthday) 47 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Norman Edher		14. MOTHER'S MAIDEN NAME UNK.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Charles Eaton 606 W. Lafayette	
18. 260 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) Hepatitis DUE TO (C) Diabetes		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 24, 1967 to May 22, 1967 , that (I) (we) last saw the deceased alive on May 22, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-23-67	
23C. PHYSICIAN'S NAME (Type) AMIRI		23D. ADDRESS M.D. 1517 Division Street Baltimore, Maryland 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5-27-67	24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR ADDRESS Mortons Dyck F.H. 1701 Laurens St.	

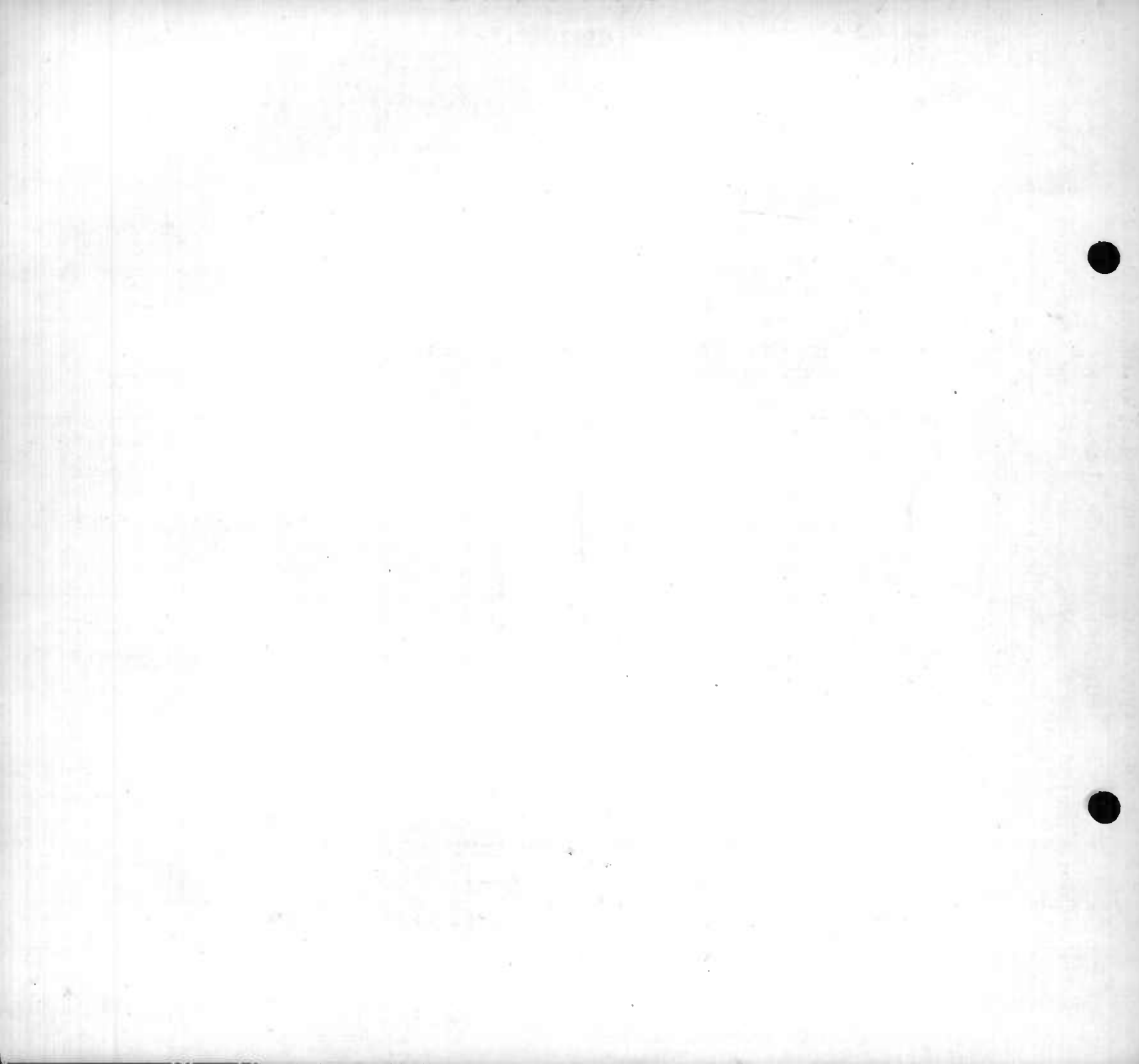


ON APPROVAL OF MEDICAL EXAMINER'S OFFICE.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5107		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5107	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) DOROTHY HARDING		
2. DATE AND HOUR OF DEATH MAY 24, 1967 10:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND. 46			A. STATE Md. B. COUNTY BALTIMORE		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-02		
			D. STREET ADDRESS (If rural, give location) 1526 N. MOUNT ST.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 009. 10. 1936	9. AGE (In years last birthday) 30	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME TITUS GARNETT, Sr.			14. MOTHER'S MAIDEN NAME ROSE CARTER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. D.	17. INFORMANT GARRETT HARDING		ADDRESS 1526 N. MOUNT ST. BALTO. Md.
18. 6450 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ACUTE CARDIAC ARREST DUE TO ACUTE BLOOD LOSS - HEMOPERITONEUM 2 HRS. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RUPTURED TUBAL PREGNANCY, RIGHT.			INTERVAL BETWEEN ONSET AND DEATH 30 MINS.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION MAY 24, 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED TUBAL PREG. RIGHT.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> NONE At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? NONE	
22. I certify that (I) (this hospital) attended the deceased from 8:45 AM 5/24 19 67 to 10:30 AM 5/24 19 67, that (I) (we) last saw the deceased alive on 10:30 AM 5/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Danilo M. Coronel, M.D.				23B. DATE SIGNED 5/24/67	
23C. PHYSICIAN'S NAME (Type) DANILO M. CORONEL				23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND, INC. 730 ASHBURTON ST. BALTO. MD. 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-24-67		24C. NAME of CEMETERY or CREMATORY Baltimore Nat'l Cem. Balto. Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS 1701 Laurens	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5108	
BIRTH NO. 67 5108		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Burke Gartrell</i>		2. DATE AND HOUR OF DEATH <i>5/24/67 6:10 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Dukeland Nursing & Convalescent Home</i> <i>1501 N. Dukeland Street</i> <i>Baltimore, Maryland 21216</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>1009 Argyle Ave.</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>6/11/96</i>	9. AGE in years (last birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SEAMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Pete Gartrell</i>				14. MOTHER'S MAIDEN NAME <i>Hattie Williams</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>542-05-7807</i>		17. INFORMANT <i>Nursing Home Chap</i>		ADDRESS	
18. <i>422.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Primary myocardial disease</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Unknown cause</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>Approx 2 yrs</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cholelithiasis, Gastric Polyps</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/24 1967</i> to <i>5/24 1967</i> and that (we) lost saw the deceased alive on <i>5/24 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Eljah Saunders</i>				23B. DATE/SIGNED <i>5/24/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>ELIJAH SAUNDERS</i>				23D. ADDRESS <i>3414 Duval Ave. Baltimore MD 21216</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-27-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Arbutus, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Morton & Dyett</i>		ADDRESS <i>1701 Laurens</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5109	
BIRTH NO.				CERTIFICATE OF DEATH	
M.E. CASE NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) CYRUS STEVENSON				2. DATE AND HOUR OF DEATH MAY 23, 1967 9:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2412 Pennsylvania Av. Baltimore, Md.				A. STATE Pennsylvania B. COUNTY Balto., Md.	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto., Md. 13-03				D. STREET ADDRESS (If rural, give location) 2537 McCulloh Street	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH 12/12/07	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman		10B. KIND OF BUSINESS OR INDUSTRY Hardware		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Stevenson		14. MOTHER'S MAIDEN NAME Naomi Griffith	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-07-5151		17. INFORMANT Charles H. Stevenson	
18. 420.121 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus				CAUSE OF DEATH (A) DUE TO Myocardial Infarction (B) DUE TO Arteriosclerotic Heart Disease (C) Unknown	
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) no	
21D. TIME OF INJURY (APPROX.) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? no	
22. I certify that (I) (this hospital) attended the deceased from October 1966 to Present , that (I) (we) last saw the deceased alive on May 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D. W. STEWART				23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) D. W. STEWART				23D. ADDRESS 3414 Luvall Av. (21216)	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-28-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION Arbutus		24E. LOCATION Arbutus		24F. LOCATION Arbutus	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Horton E. Dyett	
25D. ADDRESS 1701 Laurens		25E. ADDRESS 1701 Laurens		25F. ADDRESS 1701 Laurens	

East 4th Street

West 4th Street

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5110	
CERTIFICATE OF DEATH											
BIRTH NO. 67 5110		M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Joseph Lee Lawrence, Sr.						2. DATE AND HOUR OF DEATH May 24, 1967 10:30 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Park Drive						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 716 N. Carrollton Avenue					
5. SEX M	6. RACE colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) sep.		8. DATE OF BIRTH 1/13/18	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plant helper				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NC		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Mose Lawrence						14. MOTHER'S MAIDEN NAME Evel Beasley					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 241-16-3373		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.					
18. 153.8 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Gastrointestinal hemorrhage (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) INTERVAL BETWEEN ONSET AND DEATH Days											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic carcinoma of the colon Months											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Apr. 17 19 67 to May 24 19 67 , that (I) (we) lost saw the deceased alive on May 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Michael E. Pelczar M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED 5/24/67			
23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SAR Surg (R) M.D.						23D. ADDRESS US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5-27-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park				24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE RECEIVED BY HEALTH DEPT. MAY 26 1967				25B. NAME OF REGISTRAR Robert E. Lawrence				25C. FUNERAL DIRECTOR ADDRESS Hortonic Dye & F.H. 1701 Laurens St.			

10

PAID

Michael C. Blagov

General 507-27 1/2
Hudson Dept. 1/4

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SARAH H. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

May 25, 1967 4:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

003112 Auchentroly Terrace

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3112 Auchentroly Terrace

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3-6-1894

9. AGE (in years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Trapp-Tabor Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FRANK BANKS

14. MOTHER'S MAIDEN NAME

ELIZA J. BANKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-20-0153

17. INFORMANT

Mr. Benjamin Johnson

ADDRESS

3112 Auchentroly

18. 443 X I

CAUSE OF DEATH

Hypertensive and arteriosclerotic
cardiovascular diseaseINTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 25, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-29-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Baltimore

(City, town, or county)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 26 1967

24B. NAME OF REGISTRAR

Robert E. Hall

24C. FUNERAL DIRECTOR

Morton E. Dyer H.F.H.

ADDRESS

1701 Laurens St.

VALLEY FORTS

POST CONTENT

Frank Banks

Received

Eliza J. Banks

Trans-Label Co. Md. U.S.A.

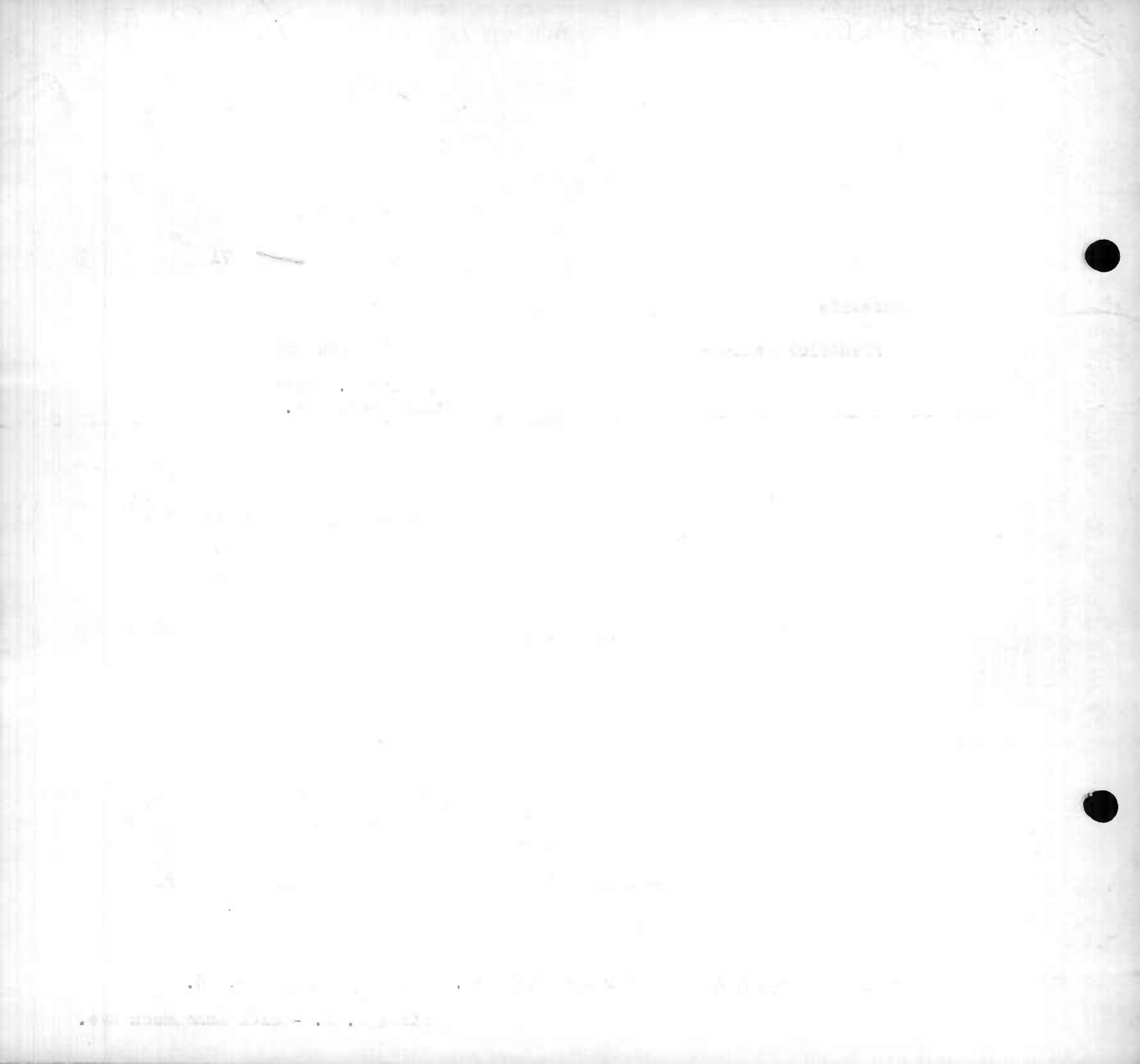
see also Mr. Benjamin Johnson and wife

Recd 2-25-02 Mt. Vernon Co. Post

Post Office Dept. Ill. 1901

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 5112				
BIRTH NO. 67 5112 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Hilda Reitz</u>					2. DATE AND HOUR OF DEATH <u>5/24/67</u> <u>2 A M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore, Inc.</u> <u>42</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>5313 Cecil Ave.</u>				
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>		8. DATE OF BIRTH <u>7/1/95</u>		9. AGE (In years lost birthday) <u>72</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Frederick Wallace</u>					14. MOTHER'S MAIDEN NAME <u>Frances Muth</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>William F. Reitz</u> <u>5313 Cecil Ave.</u>			ADDRESS	
18. <u>171X+1260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertension, Diabetes mellitus</u>					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
					(A) <u>Uremia</u> DUE TO			<u>1 week</u>	
					(B) <u>Carcinoma of the cervix</u> DUE TO			<u>? (3wk history) (of complaints)</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that <u>it</u> (this hospital) attended the deceased from <u>5/17</u> 19 <u>67</u> to <u>5/24</u> 19 <u>67</u> , that <u>it</u> (we) lost saw the deceased alive on <u>5/24</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>it</u> (We) (did) <u>(did not)</u> view the body after death.									
23A. SIGNATURE <u>Stephen P. Cohen</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>							23B. DATE SIGNED <u>5/24/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>Stephen P. Cohen</u> M.D.					23D. ADDRESS <u>Sinai Hospital of Baltimore, Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/27/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 26 1967</u>			25B. NAME OF REGISTRAR <u>John E. Feltman</u>			25C. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5113	
BIRTH NO. 67 5113		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) RAWLEIGH Myrtle		2. DATE AND HOUR OF DEATH 5/25/1967 6:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland		A. STATE Md B. COUNTY Balto Co.			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED (Specify) WIDOWED DIVORCED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 1-30-1898 9. AGE (In years last birthday) 68	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Late - George Letmate	
14. MOTHER'S MAIDEN NAME Late - Martha		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Martha Doyle		ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO cardiac failure (B) DUE TO bilateral pneumonia (C)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 5/19/1967 to 5/25/1967 that (we) last saw the deceased alive on 5/25/1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. Rajai		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/25/67	
23C. PHYSICIAN'S NAME (Type) IRAJ. REJAIE		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67		24C. NAME of CEMETERY or CREMATORY St. Paul's Cem., Druid Hill Pk. Balto., Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		ADDRESS			



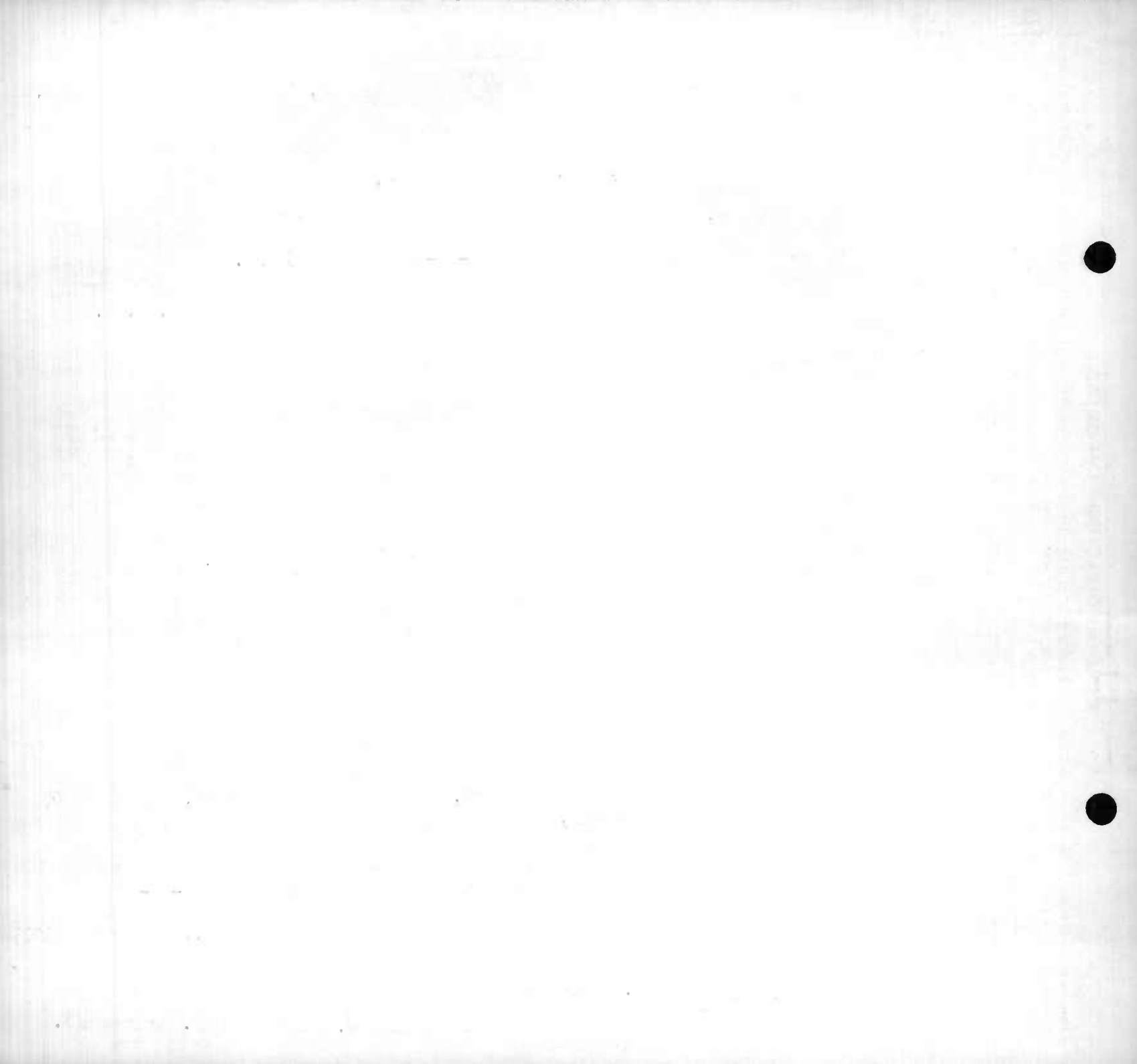
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5114	
BIRTH NO. 67 5114		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARCUS DAVIS		2. DATE AND HOUR OF DEATH 24 MAY 1967 2²² A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 18-01 D. STREET ADDRESS (If rural, give location) 853 VINE ST.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/4/10	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sumter Co. SC	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Luke Davis		14. MOTHER'S MAIDEN NAME Sarah			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 247-20-0239		17. INFORMANT ANNA Davis ADDRESS 853 VINE ST.	
18. 493 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CHRONIC OBSTRUCTIVE LUNG disease DUE TO (B) RIGHT HEART failure (A) DUE TO (C) (L) LUNG pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 15 MAY 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED pulmonary ventilation		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11 MAY 1967 to 24 MAY 1967 , that (I) (we) last saw the deceased alive on 24 MAY 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. P. Wenzel M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 24 MAY 1967			
23C. PHYSICIAN'S NAME (Type) RICHARD P. WENZEL M.D.		23D. ADDRESS UNIVERSITY REDUCED NO. 116 Green St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Shipped	24B. DATE 5/28/67	24C. NAME OF CEMETERY or CREMATORY Sumter		24D. LOCATION (City, town, or county) (State) Sumter Co. SC.	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Charles E. Farber		25C. FUNERAL DIRECTOR Williams Funeral Home ADDRESS 3199 Schaefer St.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 5115	
BIRTH NO. 67 5115		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Clarence Jackson		2. DATE AND HOUR OF DEATH May 24, 1967 2:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217 (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1302 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 725 Newington Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married 4 1	8. DATE OF BIRTH 3-23-11	9. AGE (In years lost birthday) 56 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Jackson				14. MOTHER'S MAIDEN NAME Elizabeth Warner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mildred Jackson (Wife)		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 434.1 I Septicemia II Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypostatic pneumonia Congenital heart failure Other Significant Conditions Contributing to the Death but not related to the disease or condition causing it. intestinal obstruction & flaccid				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 22, 19 67 to May 24, 19 67 , that (I) (we) last saw the deceased alive on May 24, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE S. SETASUBAN				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-24-67	
23C. PHYSICIAN'S NAME (Type) S. SETASUBAN				23D. ADDRESS M.D. 1514 Division Street Balto., Maryland 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/27/67		24C. NAME of CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Brooklyn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Charles A. Rice		25C. FUNERAL DIRECTOR ADDRESS 661 W. Barre St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5116		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5116	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELMER CORDISH		2. DATE AND HOUR OF DEATH 5/21-67 12³⁰ P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Convalescent Home		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 610 S. PACA ST. 22-02	
5. SEX MALE	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH Jan 16-1889	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-01-8808		17. INFORMANT Records -	
18. 151X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA OF STOMACH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/19/67 19 to 5/21/67 19, that (I) (we) lost saw the deceased alive on 5/21/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] M.D.				23B. DATE SIGNED 5/21/67	
23C. PHYSICIAN'S NAME (Type) HOLMA DENNARINE M.D.				23D. ADDRESS 930 WHITEWOOD ST, BALTIMORE MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5/25/67		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Baltimore Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Charles A. Rice		25D. ADDRESS 661 W. Barre St			

Green in Green

2/10/12

2/10/12

2/10/12

John Green

John Green

2/10/12

John Green

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
(Type or Print)

EDITH CORNISH

2. DATE AND HOUR PRONOUNCED DEAD

May 21, 1967

5:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 709½ S. Fremont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

709½ S. Fremont Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

W.

8. DATE OF BIRTH

May 10, 1896

9. AGE (in years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Unk.

14. MOTHER'S MAIDEN NAME

Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

E. Wilson 668 Melvin Dr.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

and
Hypertensive/arteriosclerotic
cardiovascular diseaseINTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(A) DUE TO

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springgate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 21, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/26/67

23C. NAME of CEMETERY or CREMATORY

Mt. Zion

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 26 1967

Charles A. Rice 661 W. Barre St.

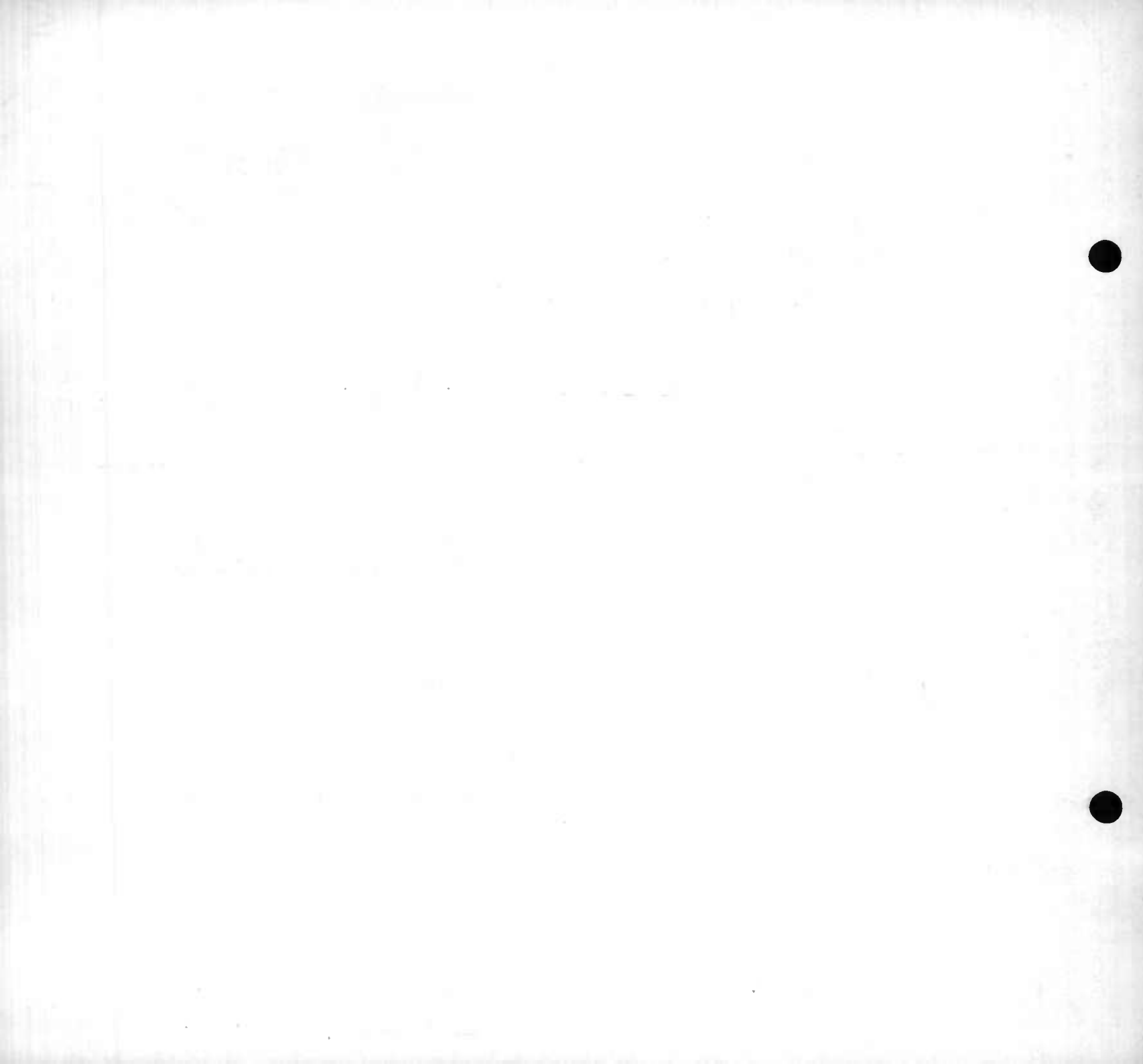
WILLY MOORE

of the

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

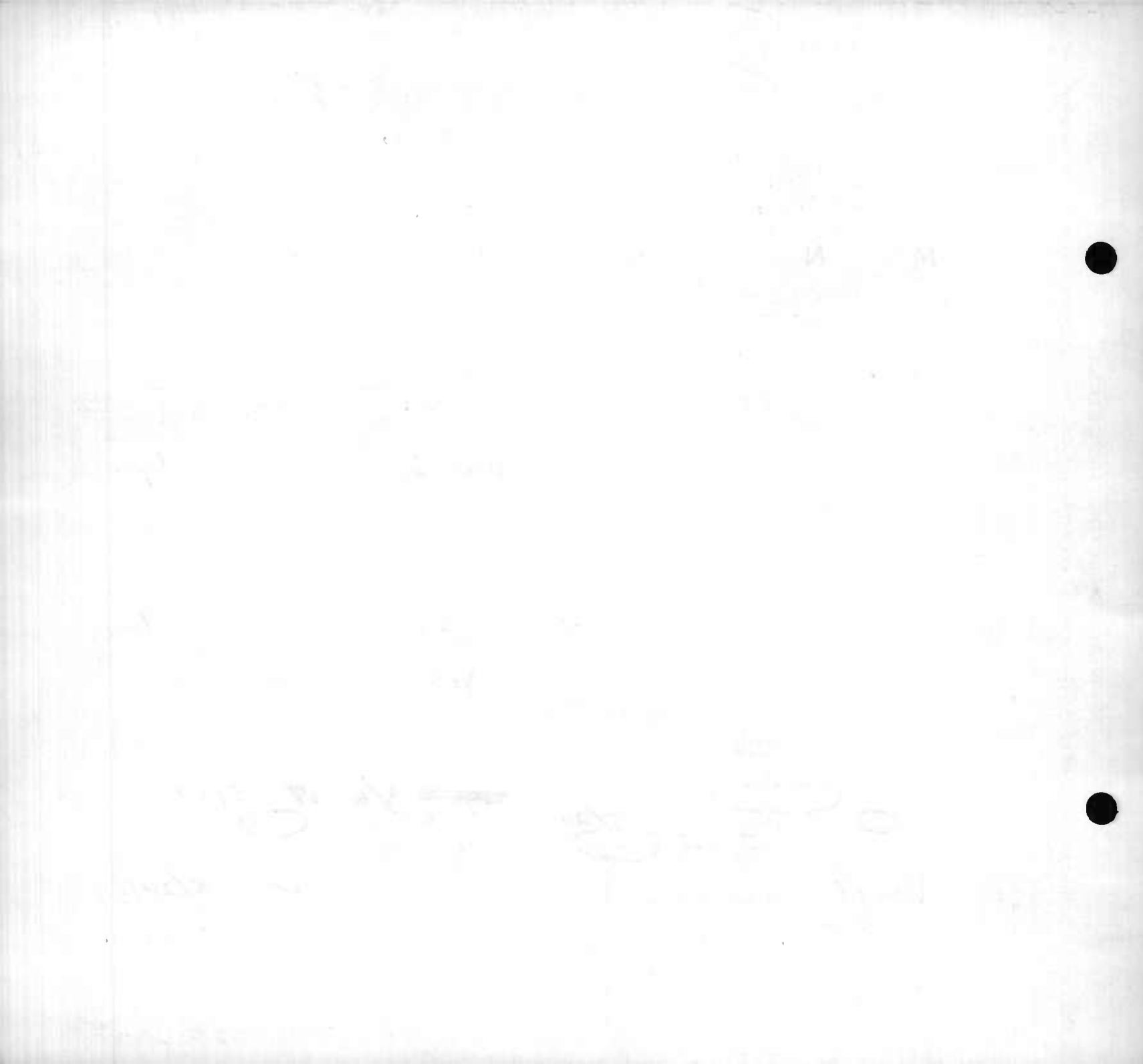
BIRTH NO. 67 5118				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 745	
M.E. CASE NO.				CERTIFICATE OF DEATH		67 5118	
1. NAME OF DECEASED (Type or Print) MELVIN F. MYERS				2. DATE AND HOUR OF DEATH 5/25/67 1 12:05 M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 201 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21231 D. STREET ADDRESS (If rural, give location) 2019 Bank Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 21, 1898	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith (Baltimore City Fire Dept.)			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States		
13. FATHER'S NAME Frederick Wm. Myers			14. MOTHER'S MAIDEN NAME Schweimborg		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no 215-03-2668-B		16. SOCIAL SECURITY NO. 215-03-2668-B
17. INFORMANT Mrs. Lida L. Myers (wife)			ADDRESS 21090 314 Church Circle Linthicum Heights				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260 X I Cerebral Vascular accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) arteriosclerosis generalized years (C) Diabetes years (D) Diabetes gangrene right foot months				INTERVAL BETWEEN ONSET AND DEATH 36 hours			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? no			
22. I certify that (I) (this hospital) attended the deceased from 3/15 19 67 to 5/25 19 67 , that (I) (we) lost saw the deceased alive on 5/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE AL H. MACHT M.D.				23B. DATE SIGNED 5/25/67			
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.				23D. ADDRESS 2 EAST READ ST 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 29, 1967		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR H. E. Myers		25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.		ADDRESS Baltimore Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

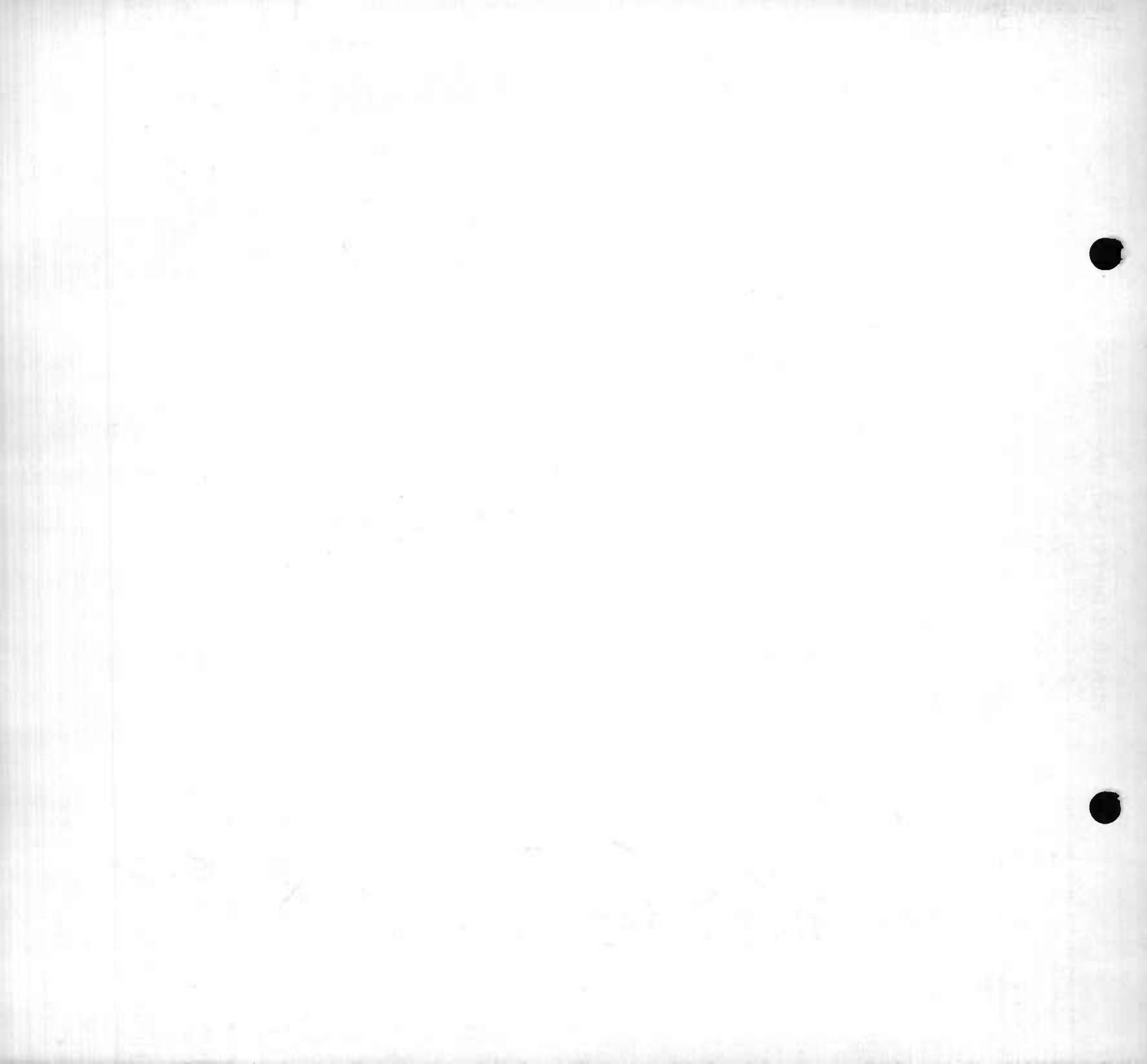
BIRTH NO. 67 5119		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5119	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lee Oliver MOONEY (Lee Oliver Mooney)		2. DATE AND HOUR OF DEATH 5/24/67		9 59 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE Maryland, B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 18-01	
		D. STREET ADDRESS (If rural, give location) 412 N. Fremont Avenue #21201			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-25-94	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Mooney		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. 212-14-1123		17. INFORMANT BCN 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Uremia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Multiple CVA's,		9 mo.	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/6 19 67 to 5/24 19 67, that (we) last saw the deceased alive on 5/24 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wm A. Emerson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/24/67	
23C. PHYSICIAN'S NAME (Type) William A. Emerson		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. #21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-29-67		24C. NAME OF CEMETERY or CREMATORY Bulto not out	
24D. LOCATION (City, town, or county) (State) Bulto md					
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Shoyl Wilson, 1001 Brantly R	



FUNERAL DIRECTOR: IMPORTANT

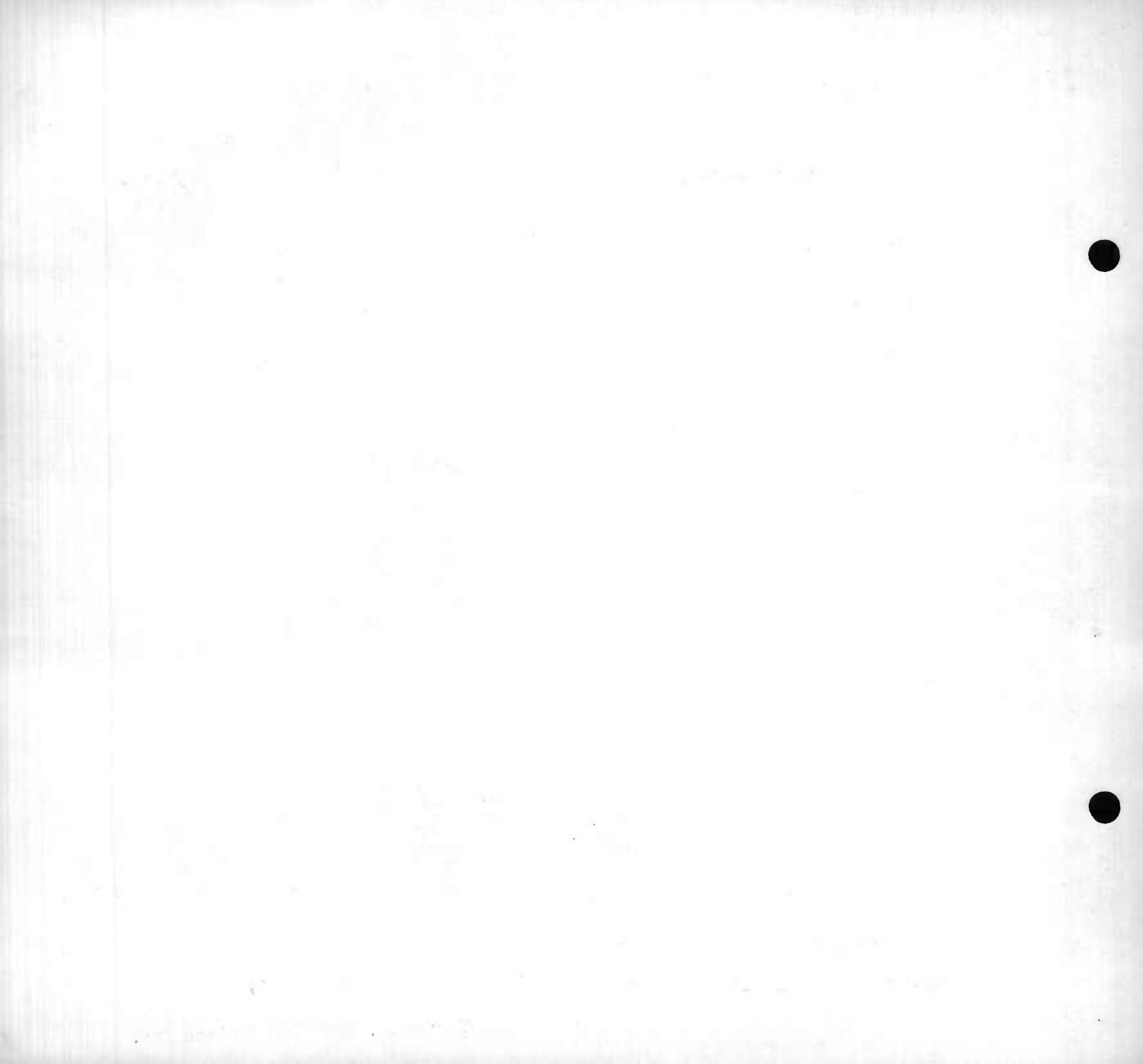
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5120	
BIRTH NO. 67 5120				CERTIFICATE OF DEATH	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) LEMON, PETER	
2. DATE AND HOUR OF DEATH 5/24/67 7:45 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital of Maryland				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 606 N. Woodington Rd	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED (specify)		B. DATE OF BIRTH 12-1-1899	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. CAR	
13. FATHER'S NAME Steffen Lemon				14. MOTHER'S MAIDEN NAME Susan Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Luther Lemon	
				ADDRESS Same	
18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO cerebral arteriosclerosis, a one day (B) DUE TO R/O malignancy (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that we (this hospital) attended the deceased from 5/23/67 to 5/27/67 that we (we) last saw the deceased alive on 5/27/67 and that our (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did view the body after death.					
23A. SIGNATURE I. Rejaie				23B. DATE SIGNED 5/24/67	
23C. PHYSICIAN'S NAME (Type) IRAJ REJAIE				23D. ADDRESS Lutheran Hospital of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-27-67		24C. NAME OF CEMETERY or CREMATORY Not Under Care	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR DR. E. E. ...		25C. FUNERAL DIRECTOR Shoyk ...	
				ADDRESS 1000 ...	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5121	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5121 CERTIFICATE OF DEATH </div>					
<div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JENIFER, DENISE </div> <div> 2. DATE AND HOUR OF DEATH 5/25/67 11:15 P.M. </div> </div>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND D. STREET ADDRESS (If rural, give location) 13-04		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 4/1/59	9. AGE (In years lost birthday) 8	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Earl Jenifer ?			14. MOTHER'S MAIDEN NAME ETTA JENIFER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT "		ADDRESS
18. 330 X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SUBARACNOID HEMOR. (Interval between onset and death: 48 Hr.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/23/1967 to 5/25/1967 , that (I) (we) last saw the deceased alive on 5/25/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sherman S. Chang				23B. DATE SIGNED 5/25/67	
23C. PHYSICIAN'S NAME (Type) SHERMAN S.M. CHANG				23D. ADDRESS SINAI Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-29-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		25B. NAME OF REGISTRAR Robert E. Edley, Jr.		25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave.	



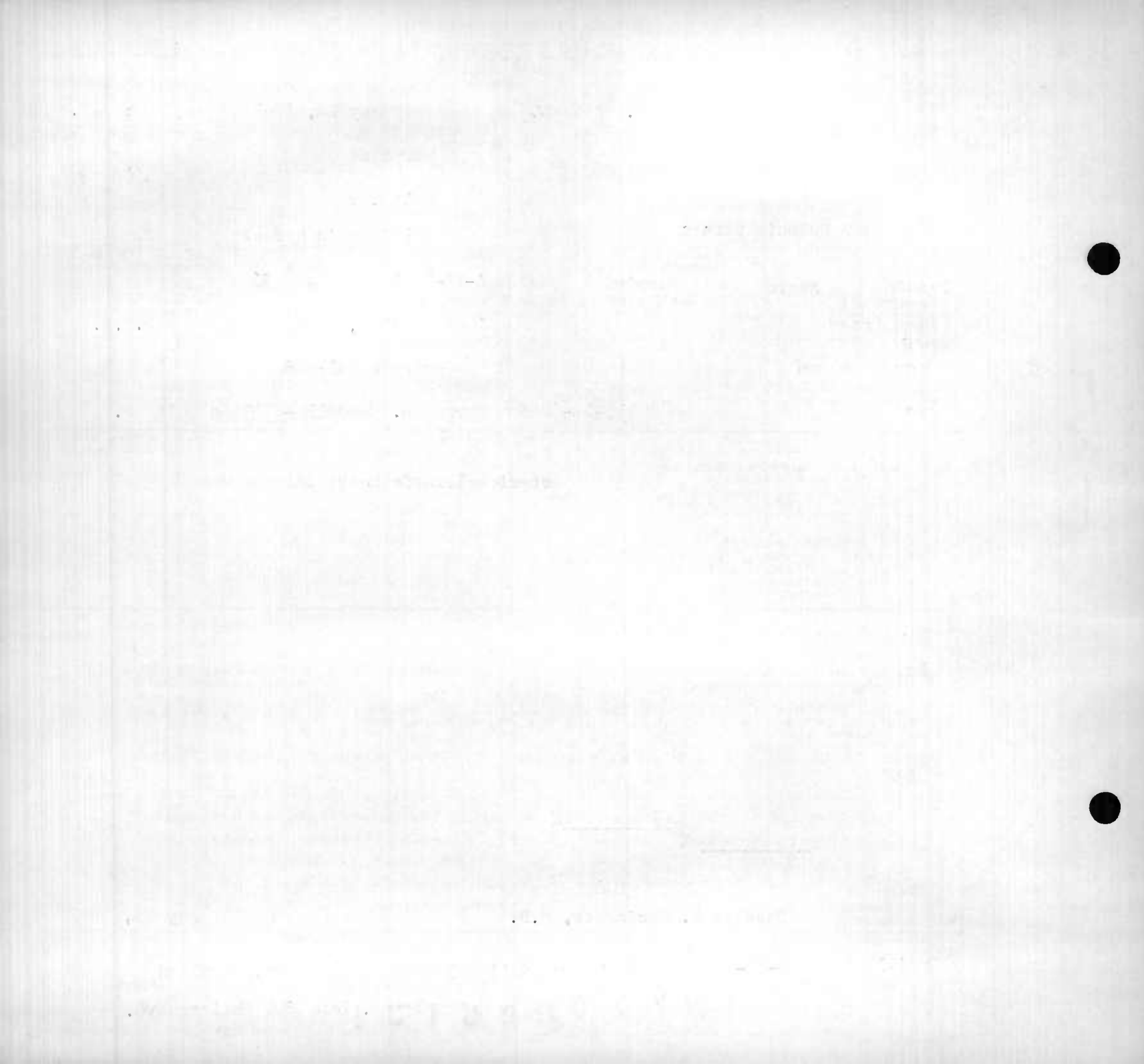
R-534

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5122

M.E. CASE NO.

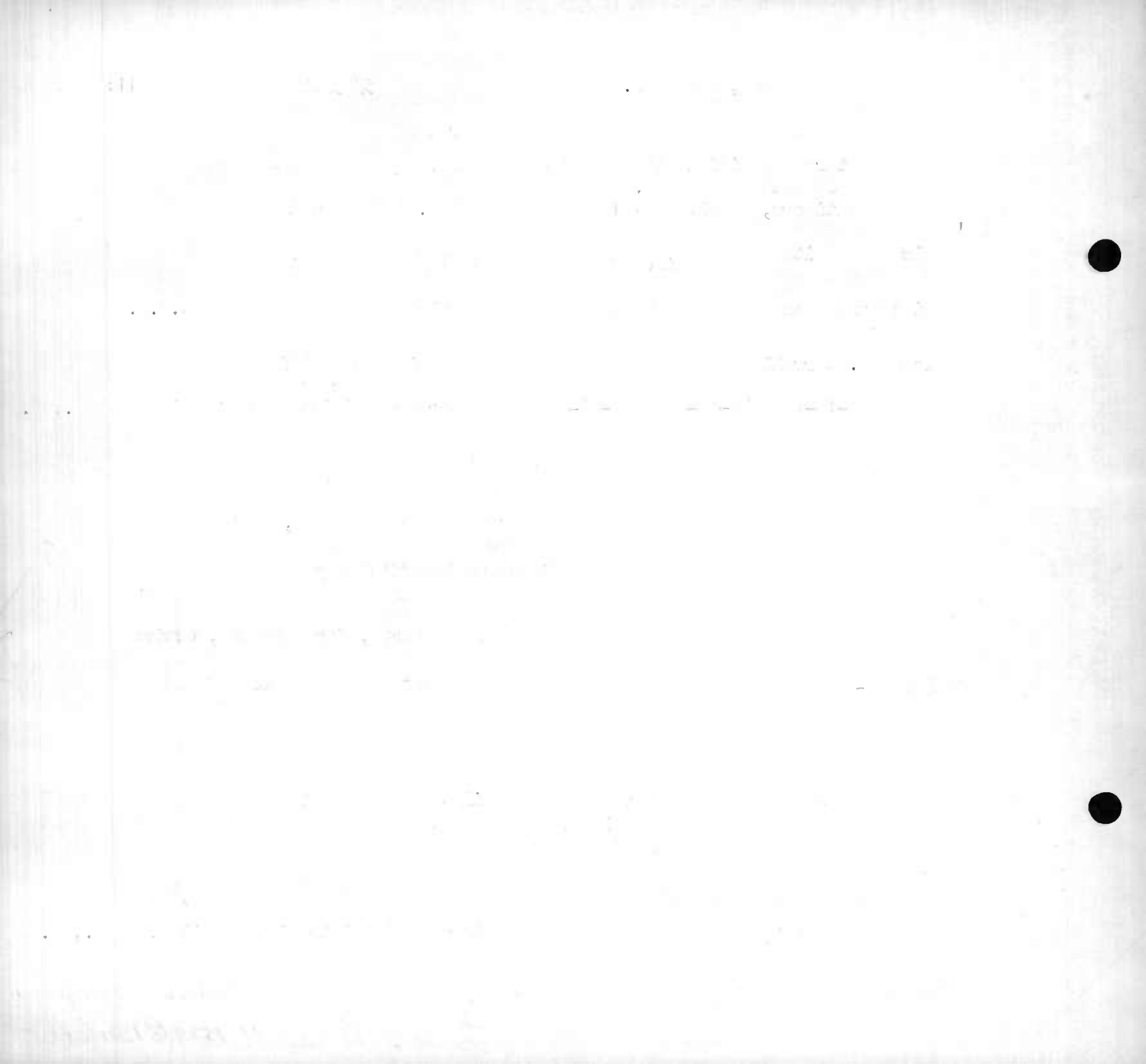
1. NAME OF DECEASED (Type or Print)		FLORENCE B. RANDALL		2. DATE AND HOUR PRONOUNCED DEAD May 24, 1967 8:40 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland	
00 307 Dolphin Street				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-04	
D. STREET ADDRESS (If rural, give location) 307 Dolphin Street					
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-15-1911	9. AGE (In years last birthday) v 56	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Simpsonsville, Maryland	
13. FATHER'S NAME George Nelson		14. MOTHER'S MAIDEN NAME Gertrude Holland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-18-6285		17. INFORMANT ADDRESS Norman A. Randall - 307 Dolphin St.	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease (A) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) DUE TO					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 25, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5-29-67		23C. NAME of CEMETERY or CREMATORY Baltimore National	
24A. DATE REC'D BY HEALTH DEPT. MAY 26 1967		24B. NAME OF REGISTRAR R. E. S. S. S.		24C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave.	
23D. LOCATION (City, town, or county) (State) Baltimore, Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5123	
BIRTH NO. 67 5123				CERTIFICATE OF DEATH	
M.E. CASE NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) CARROLL, Thomas I.				2. DATE AND HOUR OF DEATH 5/23/67 11:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 28 Veterans Administration Hospital 39 00 Loch Raven Blvd. Baltimore, Maryland 21218				A. STATE Maryland B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-07 Baltimore	
				D. STREET ADDRESS (If rural, give location) 700 W. 40th Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/19/93	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George E. Carroll	
14. MOTHER'S MAIDEN NAME Katherine McLaughlin				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4-13-17 To 1-13-19	
16. SOCIAL SECURITY NO. 216-01-0776				17. INFORMANT ADDRESS Records Veterans Administration Hospital Balto., Md.	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>46121-0021</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>? Sepsis</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) DUE TO,</p> <p>(B) Infected amputated stump, left probably gas gangrene</p> <p>(C) Vascular insufficiency</p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p>Tuberculosis, pulmonary, far advanced, active</p>					
19A. DATE OF OPERATION 5/11/67-5/22/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from April 12 19 67 to May 23 19 67 , that (1) (we) last saw the deceased alive on May 23 19 67 and that in (2) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Crisler, M.D.				23B. DATE SIGNED 5/24/67	
23C. PHYSICIAN'S NAME (Type) CARLE Crisler				23D. ADDRESS M.D. Veterans Administration Hospital, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-26-67		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR ADDRESS Lillian A. Camell 1529 E. North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5124	
BIRTH NO. 67 5124		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) TRACEY L. SMYTHE		2. DATE AND HOUR OF DEATH 5/23/67 1:16 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL		A. STATE MD B. COUNTY CECIL Co.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) NORTHEAST NORTH EAST 57-00			
		D. STREET ADDRESS (If rural, give location) 103 WALNUT ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11-19-56	9. AGE (In years last birthday) 10	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME ROGER K. SMYTHE		14. MOTHER'S MAIDEN NAME ALBERTHA MEEKINS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Albertha M. Smythe, Northeast, Md.	
18. 5/23/67 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) CARDIORESPIRATORY ARREST DUE TO		10 MIN	
		(B) ASPIRATION DUE TO		45 MIN	
		(C) UREMIA		11 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		? GOLD TOXICITY WITH ANURIA, THROMBOCYTOPENIA, LIVER FAILURE			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 28 1967 to MAY 23 1967 , that (I) (we) last saw the deceased alive on MAY 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Duane F. Alexander M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) DUANE F. ALEXANDER M.D.				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-26-67		24C. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery	
				24D. LOCATION (City, town, or county) (State) Port Deposit, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Lee G. Patterson & Son ADDRESS Pennington, Md.	

Diane F. Alexander
John F. Alexander

John F. Alexander

X

2/23/63

May 23 - 63

April 28 - 63 May 23 - 63

YES

Amnesia, incoherence, lack of
? good toxicity with

Uremia

Aspiration

Cardiorespiratory arrest 10 min

ABERTHA MEEKINS

ROGER K. SMYTHE

F W 11-18-26 10

103 WAINW 26

JOHN F. HARRIS HOSPITAL

NOV 1963

MD

TRACY, SMYTHE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5125	
BIRTH NO. 67 5125		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Dodson, Claude C.</u>		2. DATE AND HOUR OF DEATH <u>May 21 1967 7:00 P M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1110 CLIFF HURST RD.,</u> <u>BALTIMORE, MD.</u>		A. STATE <u>Maryland</u> B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1110 Cliffhurst Rd.,</u>			
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>11 Oct. 1906</u>	9. AGE (In years lost birthday) <u>60</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>medical doctor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>US Army</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Walter H. Dodson</u>		14. MOTHER'S MAIDEN NAME <u>Suzanna Long</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>retired 1962</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Claude C. Dodson, Jr.</u>	
				ADDRESS <u>8710 Manchester Rd. Silver Spring, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>163 X I</u>		CAUSE OF DEATH (A) <u>Pulmonary hemorrhage</u> DUE TO (B) <u>Cancer (lung)</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>2 years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 10 1963</u> to <u>May 21 1967</u> , that (I) (we) lost saw the deceased alive on <u>May 20 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John L. Enkari</u>				23B. DATE SIGNED <u>May 21st 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>John L. ENKARI</u>				23D. ADDRESS <u>5601 Paulington Way, Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>24 May 1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Arlington National</u>	
24D. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 29 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Rinaldo Funeral Home, Washington, DC</u>	
				ADDRESS <u>Wm. L. Edmonds with L.P.A.</u>	

1. 1. 1.

2. 2. 2.

3. 3. 3.

4. 4. 4.

5. 5. 5.

6. 6. 6.

7. 7. 7.

8. 8. 8.

9. 9. 9.

10. 10. 10.

11. 11. 11.

12. 12. 12.

13. 13. 13.

14. 14. 14.

15. 15. 15.

16. 16. 16.

17. 17. 17.

18. 18. 18.

19. 19. 19.

20. 20. 20.

21. 21. 21.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5126	
BIRTH NO. 67 5126		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Leila Childs</i>		2. DATE AND HOUR OF DEATH <i>5/20/67 12:10 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Bolton Hill Nrsng. Home</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 14-03</i>			
		D. STREET ADDRESS (If rural, give location) <i>1802 Eutaw Place</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9/12/1882</i>	9. AGE (In years lost birthday) <i>95</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Henry Kennan</i>			14. MOTHER'S MAIDEN NAME <i>Susan McKinnon</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Mrs. John Staib 8415 Bellorey Lane</i>		
18. I <i>450.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>CANCRE OF Rt Foot</i> (A) DUE TO <i>ARTERIOCLEROSIS</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/10/67</i> 19 to <i>5/20/67</i> 19 that (I) (we) last saw the deceased alive on <i>5/20</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>HOLLIS J. J. J. J.</i>		23D. ADDRESS <i>930 W. TENDOCK ST. BALTIMORE MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>	24B. DATE <i>5-23-67</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Edge Hill Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Charles Town, W. Va.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 29 1967</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>Charles Town, W. Va.</i>	

INTERVIEWED
Sergeant of the Post

2/10/72

James J. [Signature]
James J. [Signature]

2/10/72

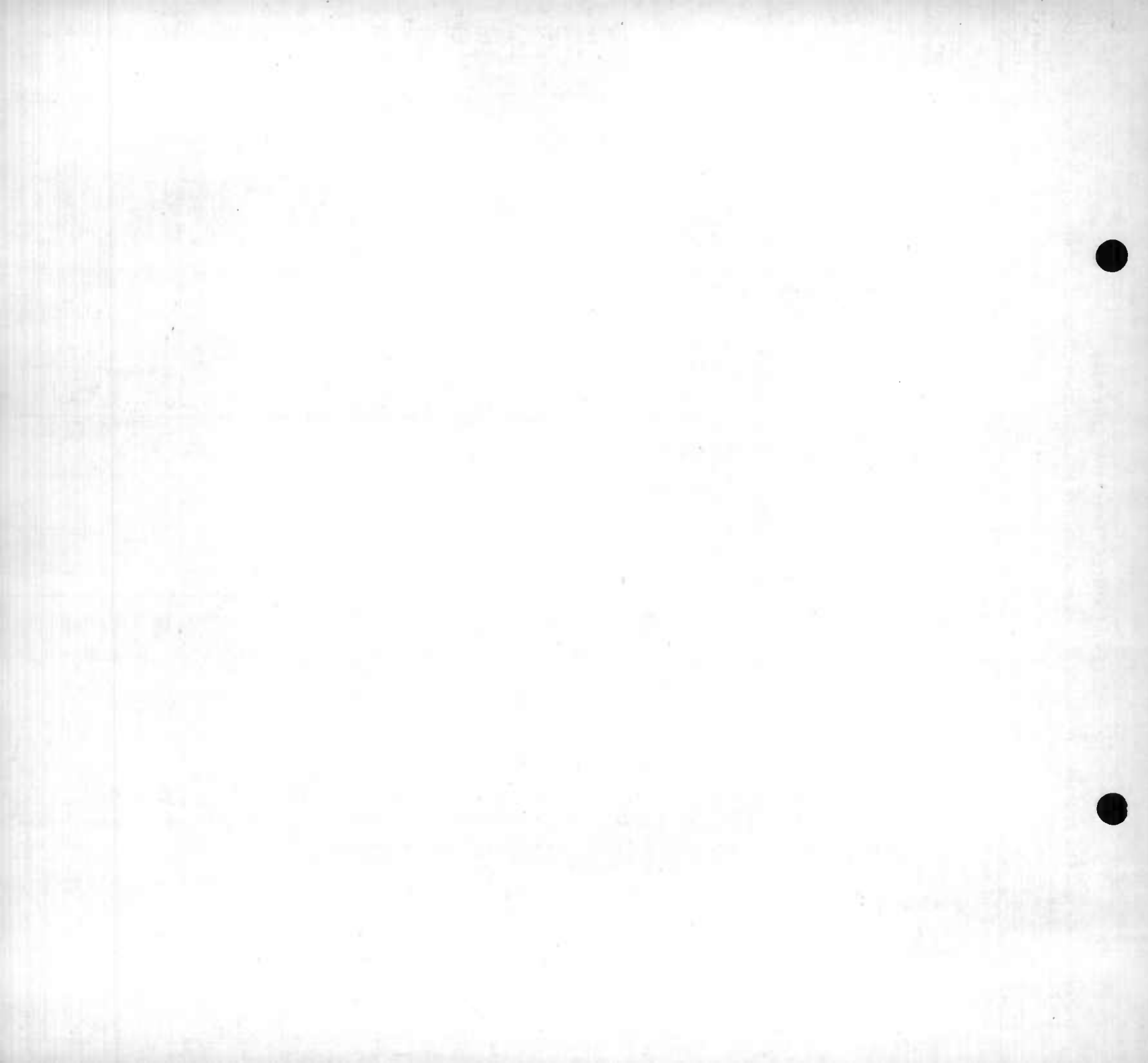
2/10/72

James J. [Signature]
James J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5127	
BIRTH NO. 67 5127											
M.E. CASE NO. Mr Leroy Winters											
1. NAME OF DECEASED (Type or Print) Leroy Winters						2. DATE AND HOUR OF DEATH 5-28-67 at 10:45 AM					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. Gen. Hosp.						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 23-03					
						D. STREET ADDRESS (If rural, give location) 1705 Patapsco St.					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Oct. 31, 1897		9. AGE (In years last birthday) 69		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Winters						14. MOTHER'S MAIDEN NAME Ella					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ada Todd - same as #11				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 286.5 I DUE TO (A) malnutrition, severe						INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3:40 A.M. 5-28-1967 to 10:45 A.M. 5-28-1967, that (I) (we) lost saw the deceased alive on 10:45 A.M. 5-28-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Maldonado M.D.						23B. DATE SIGNED 5-28-67				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) MALDONADO, BA.						23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-31-67		24C. NAME OF CEMETERY or CREMATORY Spudon Park Cem.				24D. LOCATION (City, town, or county) (State) BALTO. Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967				25B. NAME OF REGISTRAR R. E. Taylor				25C. FUNERAL DIRECTOR McCully - 130 E. Fort Ave. BALTO. 30, Md.			



S-000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5128				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5128	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LEE K. SUEY				2. DATE AND HOUR OF DEATH MAY 25, 1967 11:53 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 4-01			
				D. STREET ADDRESS (If rural, give location) 312 PARK AVE. 21201			
5. SEX M	6. RACE Chinese	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 1899-?	9. AGE (In years lost birthday) 70	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER		10B. KIND OF BUSINESS OR INDUSTRY CHINESE RESTAURANT		11. BIRTHPLACE (State or foreign country) CHINA		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME could not ascertain				14. MOTHER'S MAIDEN NAME could not ascertain			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 104-14-4825		17. INFORMANT ADDRESS Mr. Jimmy Wu 2400 N. Charles St. 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260 X I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Pneumonia - streptococcal DUE TO (B) Diabetes Mellitus DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/16/67 to 5/25 1967, that (I) (we) last saw the deceased alive on 5/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald Goldner				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/25/67	
23C. PHYSICIAN'S NAME (Type) RONALD GOLDNER				23D. ADDRESS 827 Linden Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE May 29, 1967		24C. NAME OF CEMETERY OR CREMATORY Lemmon		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Ruth E. Tolson		25C. FUNERAL DIRECTOR Stewart Morris		ADDRESS 108 W. 7th St. 21304	

MAY 1951

MAY 1951

MAY 1951

MAY 1951

TO

CHINESE

WATER

CHINA

RESTAURANT

WATER

1041-1012 Mr. Jimmy Wu 1400 of Canton St.

1041-1012

1041-1012

1041-1012

1041-1012

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5129		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5129	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Harry S. CHAN		2. DATE AND HOUR OF DEATH 5-23-67 5:30 AM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		C. CITY OR TOWN (If outside city, limits, write RURAL and give township) Baltimore 4-01	
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 322 PARK AVE	
5. SEX M	6. RACE Chinese	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH ?	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) China	
12. CITIZEN OF WHAT COUNTRY? Naturalized Citizen		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 213-48-7410		17. INFORMANT - COUSIN - M.E. CHAN - 702 E. Preston St. - City	
18. 334 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular disease Generalized atherosclerosis		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1:22 5/22/67 19 to 5:33 5/23 19 67, that (I) (we) last saw the deceased alive on 3 AM 5/23/67 PM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE I. Honarvar M.D.				23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) Iraj-Honarvar M.D.				23D. ADDRESS Maryland General Hospital Baltimore, Md.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE May 26/67		24C. NAME OF CEMETERY or CREMATORY Lorraine	
24D. LOCATION (City, town, or county) (State) Woodlawn Md		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR E. E. E.	
25C. FUNERAL DIRECTOR S. E. E.		25D. ADDRESS 108 W. W. W.			

385 Park Ave

10-10-12

Director

Doc

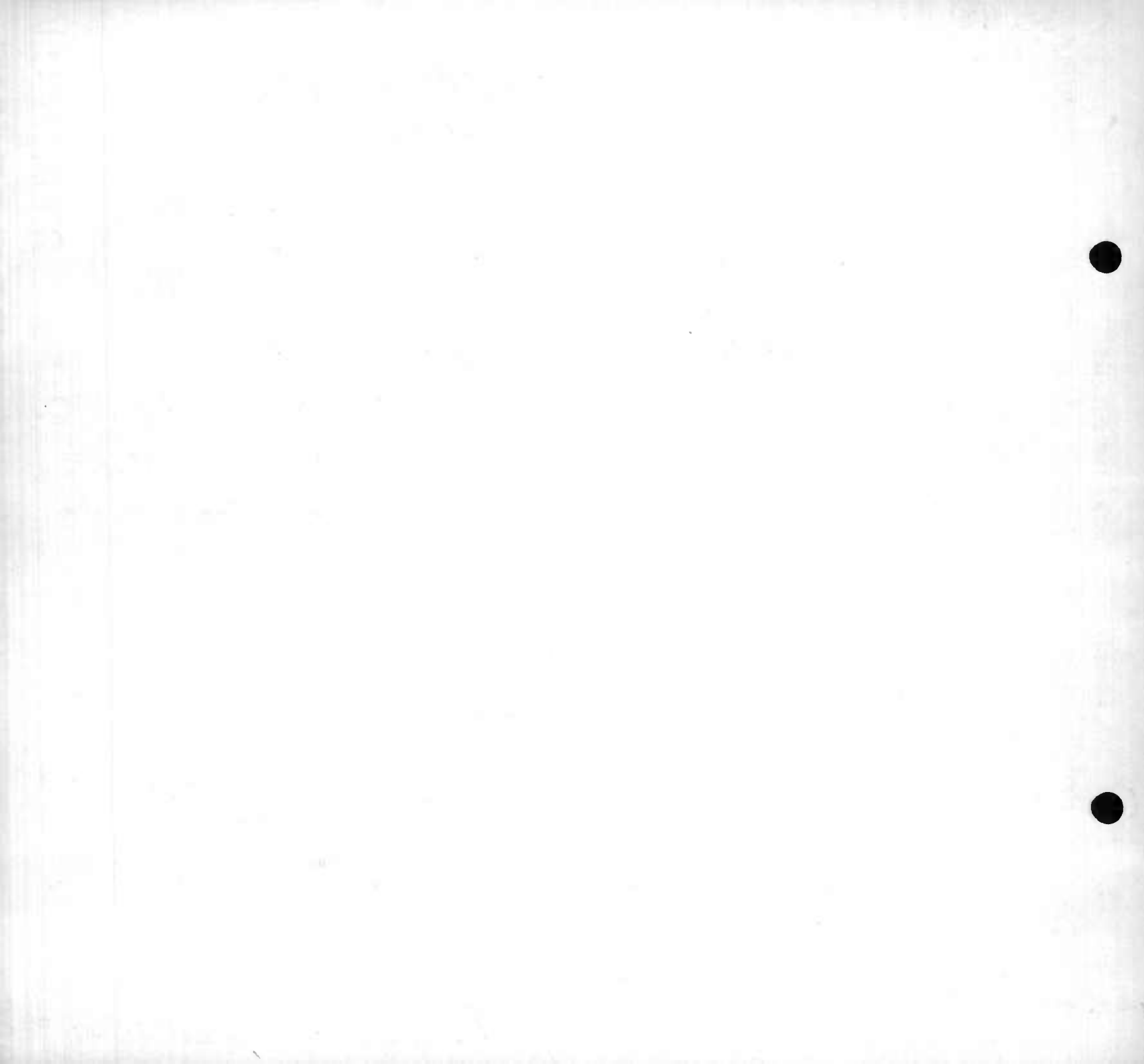
Chas

M. C. Ham - 108 - 108 - 108

du

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5130	
BIRTH NO. 67 5130		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARTIN Emil Radtke		2. DATE AND HOUR OF DEATH May 24 1967 3:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 729 Colorado Avenue			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH Dec 17 1910	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Food Store		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Emil Radtke			14. MOTHER'S MAIDEN NAME Gertrude Ridgely		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 01 8586		17. INFORMANT Agusta Radtke	
				ADDRESS 729 Colorado Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) Mycardial infarction DUE TO		INTERVAL BETWEEN ONSET AND DEATH 12 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Atherosclerotic Cardiovascular Disease DUE TO		12 yrs.	
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None					
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 4-28 19 55 to 5-10 19 67 , that (I) (we) last saw the deceased alive on 5-10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sydney Scherlis M.D.				23B. DATE SIGNED 5-26-67	
23C. PHYSICIAN'S NAME (Type) Dr Sidney Scherlis M.D.				23D. ADDRESS 11 E Chase St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-27-67		24C. NAME OF CEMETERY or CREMATORY Wesley Chapel Cem.	
24D. LOCATION (City, town, or county) (State) Rock Hill Kent Co Md		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Burmes Funeral Home			
		ADDRESS 3631 Falls Rd			



14-160 67 5131

BALTIMORE CITY HEALTH DEPARTMENT

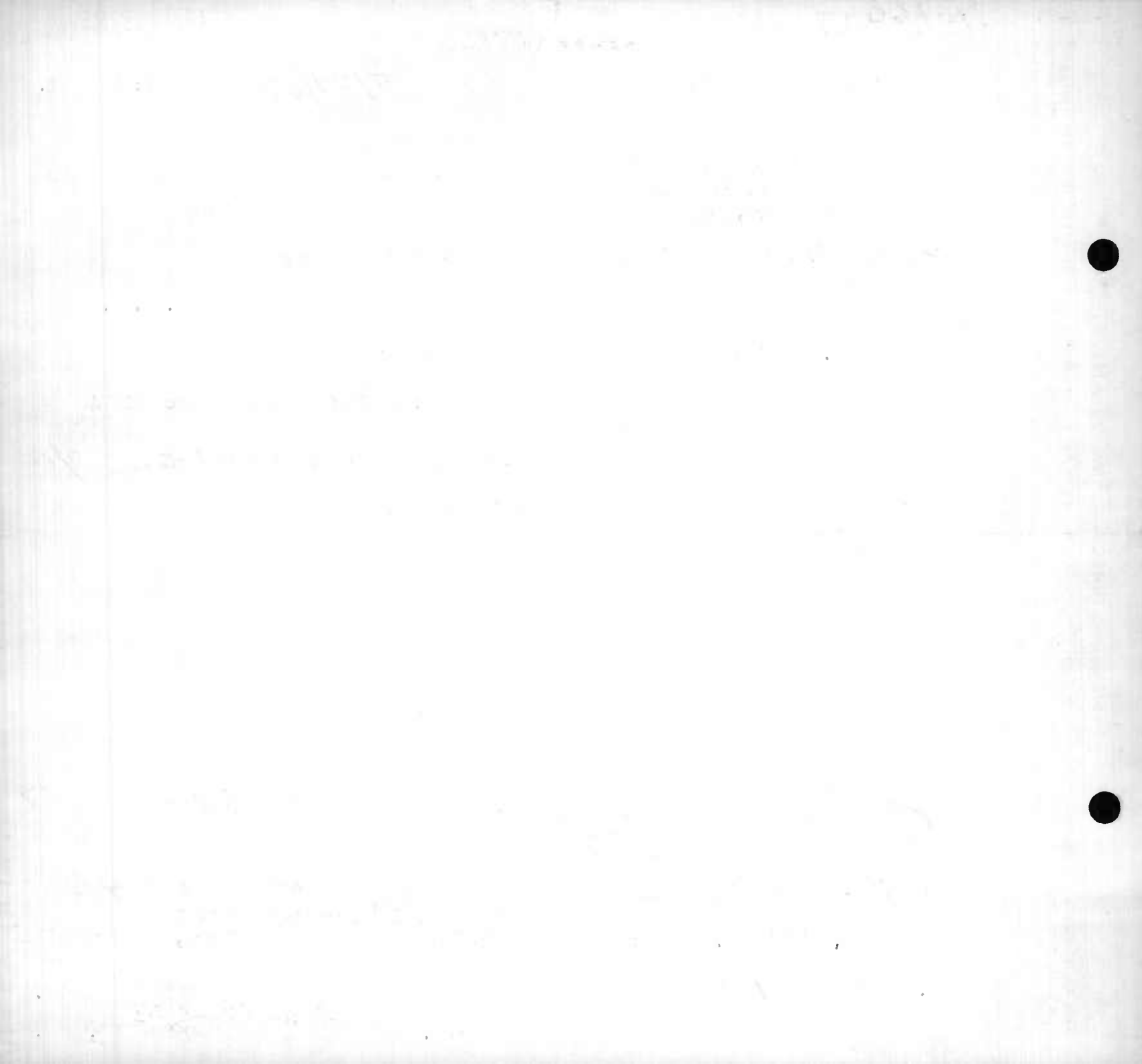
CERTIFICATE OF DEATH

Registered No. 67 5131

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Hattie Hooper</i>		2. DATE AND HOUR OF DEATH <i>5/24/67</i> <i>7:30</i> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>X</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>1035 Orleans Street 21202</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>		8. DATE OF BIRTH <i>11-27-00</i>	9. AGE (In years lost birthday) <i>66</i>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William H. Cornish</i>				14. MOTHER'S MAIDEN NAME <i>Ada Hooper</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>RECORDS: BCM 4940 Eastern Avenue 21224</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>260 X I</i> <i>ASCVD & basilar + cerebral stenosis</i> <i>3/66</i> <i>Diabetes Mellitus</i>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH <i>3/66</i>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/13/67</i> to <i>5/24/67</i> and that (I) (we) last saw the deceased alive on <i>5/24/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>William A. Emerson</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/24/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. William A. Emerson</i>				23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue Baltimore, Maryland 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>5/27/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>TAYLORS ISLAND</i>		24D. LOCATION (City, town, or county) (State) <i>TAYLORS ISLAND DOVERCHESTER MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 29 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>ST. CLAIR FUNERAL HOME</i> <i>CAMBRIDGE, MD.</i>			



CERTIFICATE OF DEATH

Registered No.

67 5132

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NELLIE WILLIS

2. DATE AND HOUR OF DEATH

5/27/67

7⁴⁵ A

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE 21224, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

BCH: 4940 EASTERN AVENUE

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

1-6-1892

9. AGE (In years
lost birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

German Clark

14. MOTHER'S MAIDEN NAME

ELLEN - - -

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 EASTERN AVENUE #21224

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

CVA's, multiple

(B) DUE TO

ASCVD

(C)

INTERVAL BETWEEN
ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 5/27 19 65 to 5/27 19 67.
that (we) last saw the deceased alive on 5/27 19 67 and that in (my) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Phillip L. Hall

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

5/27/67

23C. PHYSICIAN'S
NAME (Type)

DR. PHILLIP L. HALL

M.D.

23D. ADDRESS

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE BALTIMORE 21224, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/30/67

24C. NAME of CEMETERY or CREMATORY

Fairview Cemetery

24D. LOCATION

(City, town, or county)

Narrow, Virginia

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 29 1967

25B. NAME OF REGISTRAR

Robert E. Farber

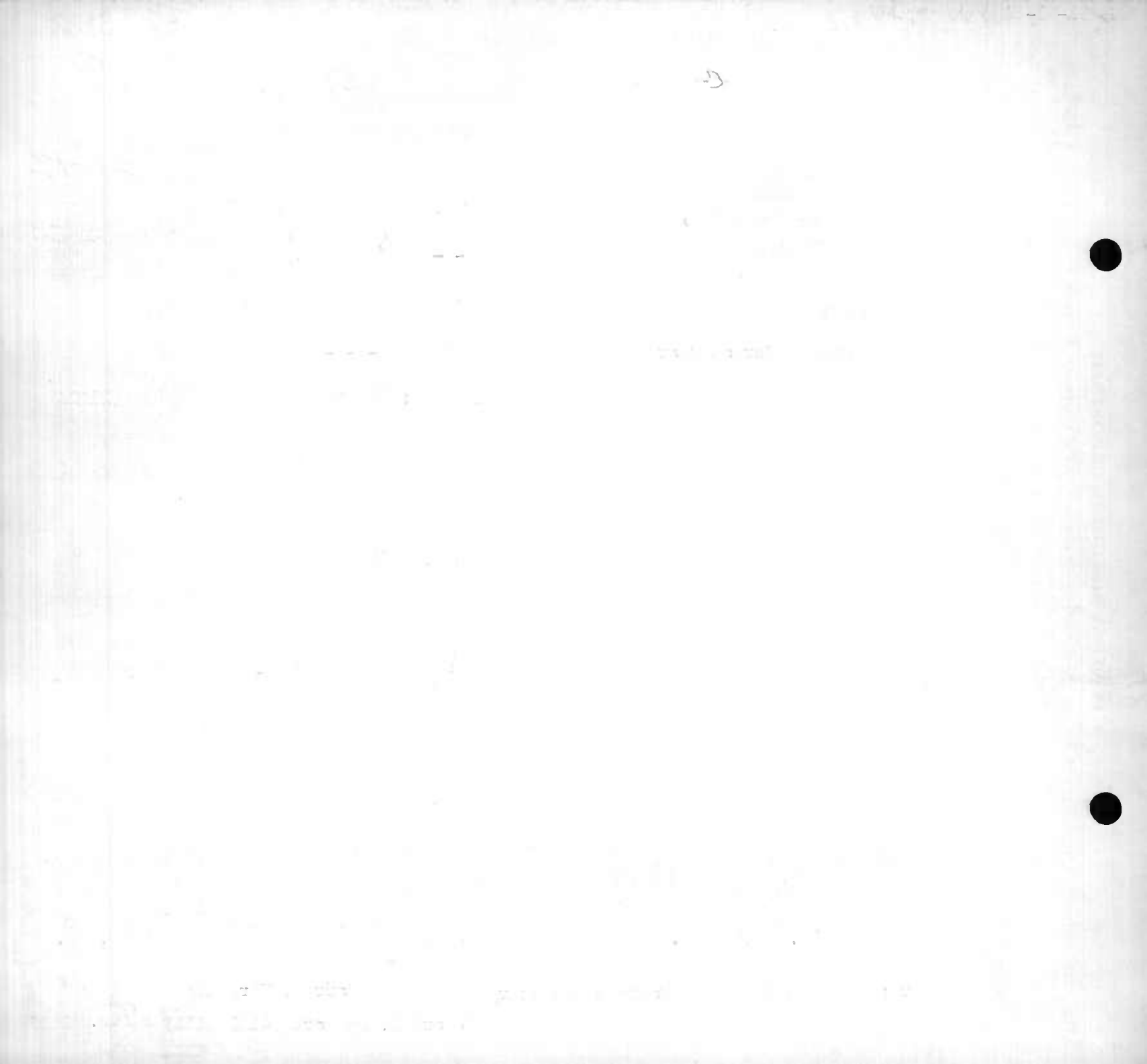
25C. FUNERAL DIRECTOR

Howard H. Hubbard 4107 Wilkens Ave. 21229

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

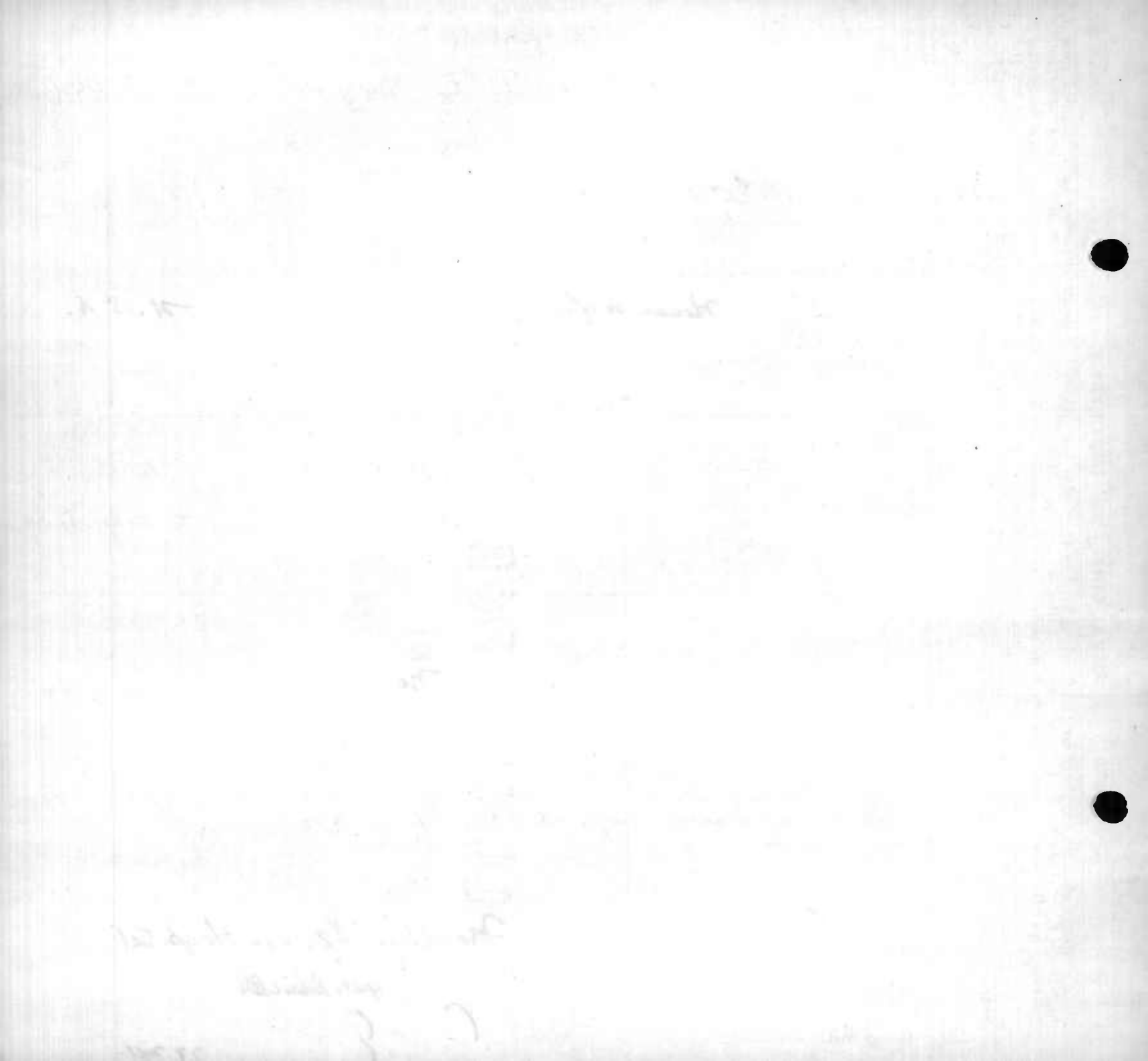
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

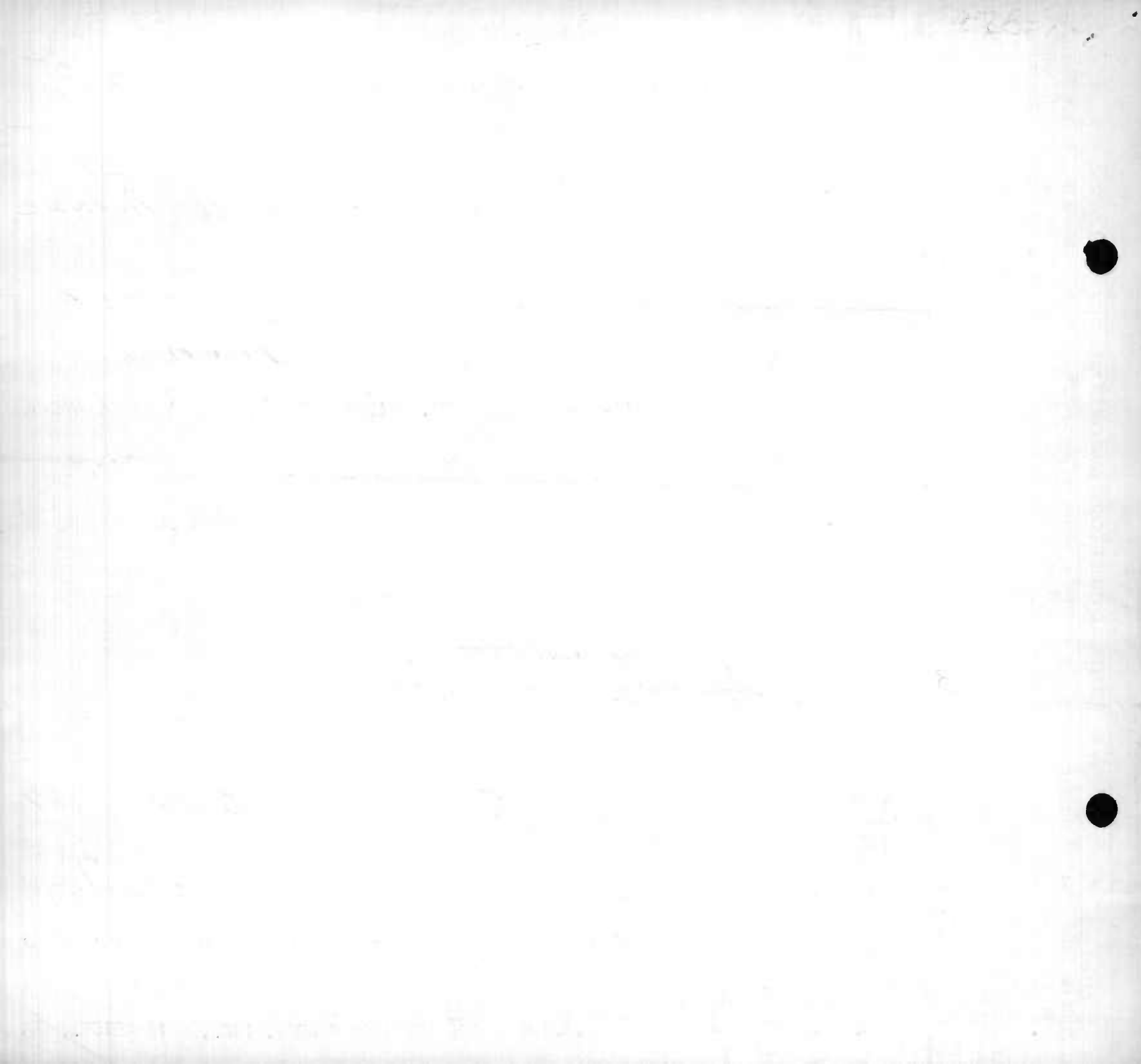
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5133	
BIRTH NO. 67 5133				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KRISS, EDNA LOUISE		2. DATE AND HOUR OF DEATH May 25, 1969 9:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21-01 D. STREET ADDRESS (If rural, give location) 835 W. BARRE ST. (21230)			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5-11-88	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House wife		11. BIRTHPLACE (State or foreign country) Baltimore, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Paul W. Beigle		14. MOTHER'S MAIDEN NAME Minnie Beigle?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-1-5-0249		17. INFORMANT Harry A. Kriss #10 35th St. Washington D.C.	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Pulmonary Edema (B) DUE TO A.S.C.U.D. (C) DUE TO Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH from ? to May 25, 69	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 11, 1969 to May 25, 1969 , that (I) (we) last saw the deceased alive on May 25, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sang Bae He,		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 25, 1969	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D. Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 5/29/69		24C. NAME OF CEMETERY or CREMATORY Valley Cedars Cemetery	
24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Balt. Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Finkler	
25C. FUNERAL DIRECTOR John J. Cowan Inc.		ADDRESS 23 Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>67 5134</u>	
BIRTH NO. <u>67 5134</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Heinman Charles Rothman</u>		2. DATE AND HOUR OF DEATH <u>5/24/67</u> <u>6:20</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4002 PRIMROSE AVENUE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper Poultry Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Rothman</u>				14. MOTHER'S MAIDEN NAME <u>Beasio</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>111-09-7020</u>		17. INFORMANT <u>MRS. HELENA ROTHMAN, 4002 PRIMROSE AVENUE</u>			
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>ASCVD</u> DUE TO (B) <u>Pulmonary embolus</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>5/20/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Uterine Cancer</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> 19 <u>67</u> to <u>5/24</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> 19 <u>67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sandra Z. Salan</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/24/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Sandra Z. Salan</u> M.D.				23D. ADDRESS <u>University of Maryland Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/25/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW YOUNG MENS</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 29 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u>		ADDRESS <u>6010 REIST., RD.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 5135	
BIRTH NO. 67 5135		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. BERTHA KAISER		2. DATE AND HOUR OF DEATH 5-25-67 3:20 pm.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE COUNTY (SPARROWS PT)	
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME + HOSP. BALTIMORE, Md. 21231		D. STREET ADDRESS (If rural, give location) 511 FST. 53-00			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1-1-00	9. AGE (In years lost birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) N.Y.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MORTIMER REIF			14. MOTHER'S MARDEN NAME Mina Bode		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-8782B		17. INFORMANT (Husband) George C. Kaiser, 511 "F" St. Sparrows Point, Maryland 21219	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) 15331		CAUSE OF DEATH Intestinal Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 1963 TO DATE	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1963, 1965, 1966		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of sigmoid		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-11-1967 to 5-25-1967 , that (I) (we) lost saw the deceased alive on 5-25-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jose G. Ortiz M.D.				23B. DATE SIGNED 5-25-67	
23C. PHYSICIAN'S NAME (Type) Ricardo M. Tuason M.D.				23D. ADDRESS Church Home + Hosp. 1000 Broadway St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Pk. Cem.	
24D. LOCATION Dorsey, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.			

Business, 11/1/21
1214 1/2

F. W. M. M. M.
M. M. M. M. M.
M. M. M. M. M.
M. M. M. M. M.

Business, 11/1/21
1214 1/2

F. W. M. M. M.
M. M. M. M. M.
M. M. M. M. M.
M. M. M. M. M.

11/1/21

Business, 11/1/21

Business, 11/1/21

11/1/21

11/1/21

11/1/21

11/1/21

11/1/21

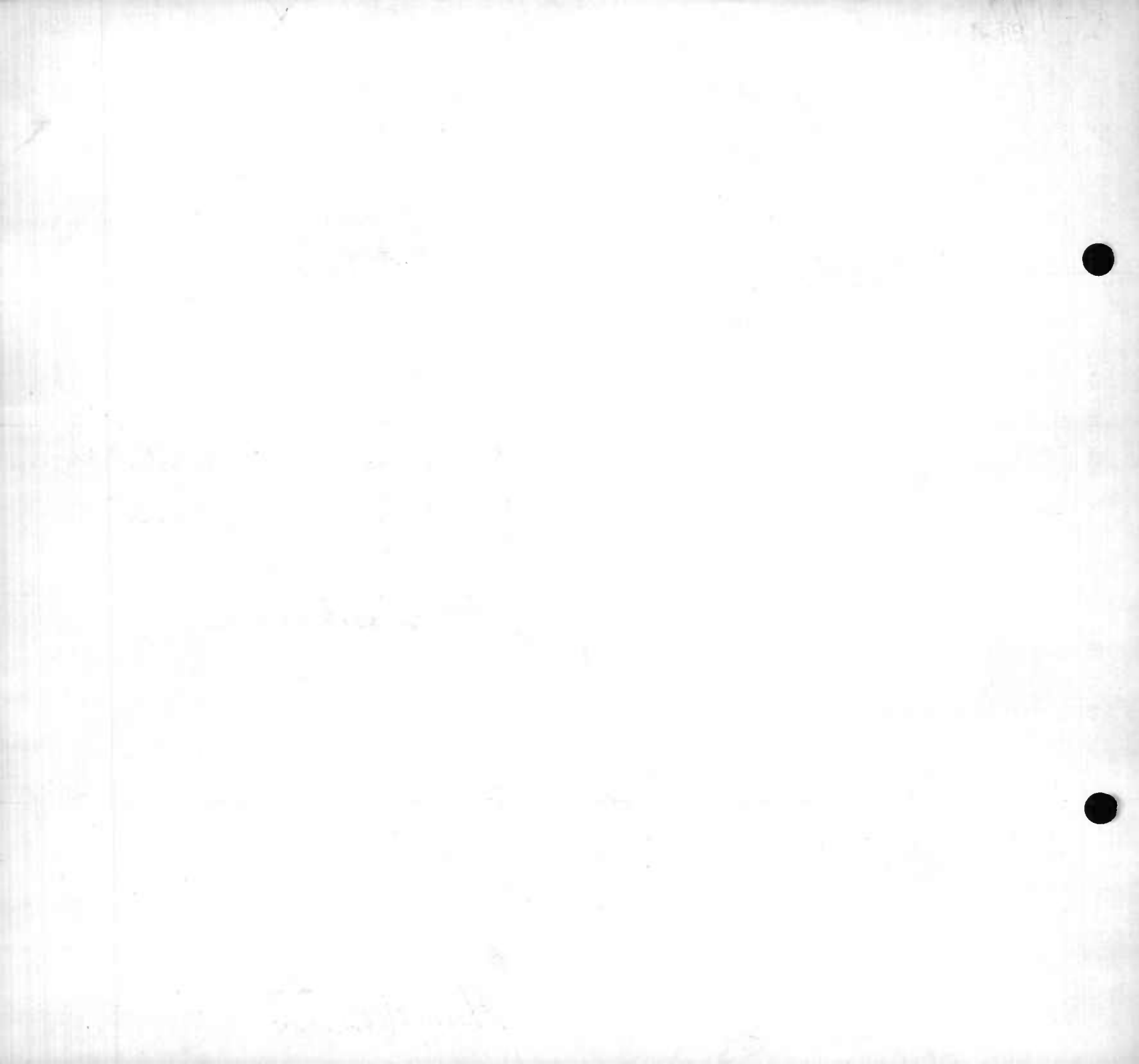
Business, 11/1/21

Business, 11/1/21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5136				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5136	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Charles A. Pfeifer		May 27, 1967	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Haven Nursing Home 3939 Penhurst Ave. Baltimore, Md. 21215				A. STATE Md. B. COUNTY Baltimore Co.			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Essex 53-00			
D. STREET ADDRESS (If rural, give location)				61 Seversky, Mars Estates			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH June 16, 1899	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 67		11. BIRTHPLACE (State or foreign country)	
Self employed		Resturant		Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Frederick Pfeifer				14. MOTHER'S MAIDEN NAME Anna Ketchum			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-09-6835A		17. INFORMANT Margaret Martin	
				ADDRESS 1342 Cedarcroft Rd. Baltimore Md. 21212			
18. 527.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Respiratory Neglect of Disease (B) DUE TO Emphysema (Disease) (C) DUE TO Swollen Arteries Cyanosis Shortness of Breath		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7:45 to 19:47, that (I) (we) last saw the deceased alive on May 26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Thomas C. Abbott				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-27-67	
23C. PHYSICIAN'S NAME (Type) Thomas C. Abbott				23D. ADDRESS 4509 Lehigh, Heights			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/1967		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Harry A. Omaco		ADDRESS 4204 Ridgewood Ave Baltimore, Md. 21215	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5137				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 5137	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) EDITH M. PEREGOV		2. DATE AND HOUR OF DEATH 5/22/67 8 ¹⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GEN'L HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore, Carroll Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) MILLERS, MARYLAND 21107		D. STREET ADDRESS (If rural, give location) UPPER BECKLEYSVILLE Rd. 5600	
5. SEX F	6. RACE Can	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 11/22/69	9. AGE (In years last birthday) 99	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN W COOPER				14. MOTHER'S MAIDEN NAME RACHEL M ROGERS-					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 246-36-8728		17. INFORMANT ADDRESS Mrs. P. Cooper, Millers, Md. 21107			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia				CAUSE OF DEATH (A) DUE TO Fractured L hip				INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days-	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, arising rise to the above cause (A) stating the UNDERLYING CONDITION last.				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING IT. ISCVD					
19A. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Upper Beckleysville-millers Md.		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 5/18/67			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall out of bed		22. I certify that (this hospital) attended the deceased from 05/17/67 19 to 05/22/67 19 that (I) (we) last saw the deceased alive on 05/22/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)					
23A. SIGNATURE Robert M. BEAZLEY M.D.				23B. DATE SIGNED 5/22/67		23C. PHYSICIAN'S NAME (Type) Robert M. Beazley M.D.			
23D. ADDRESS MARYLAND GEN'L HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE May 26/1967		24C. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		24D. LOCATION (City, town, or county) (State) Parkton, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR [illegible]		25D. ADDRESS [illegible]					

Baltimore

97

Washington, D.C.

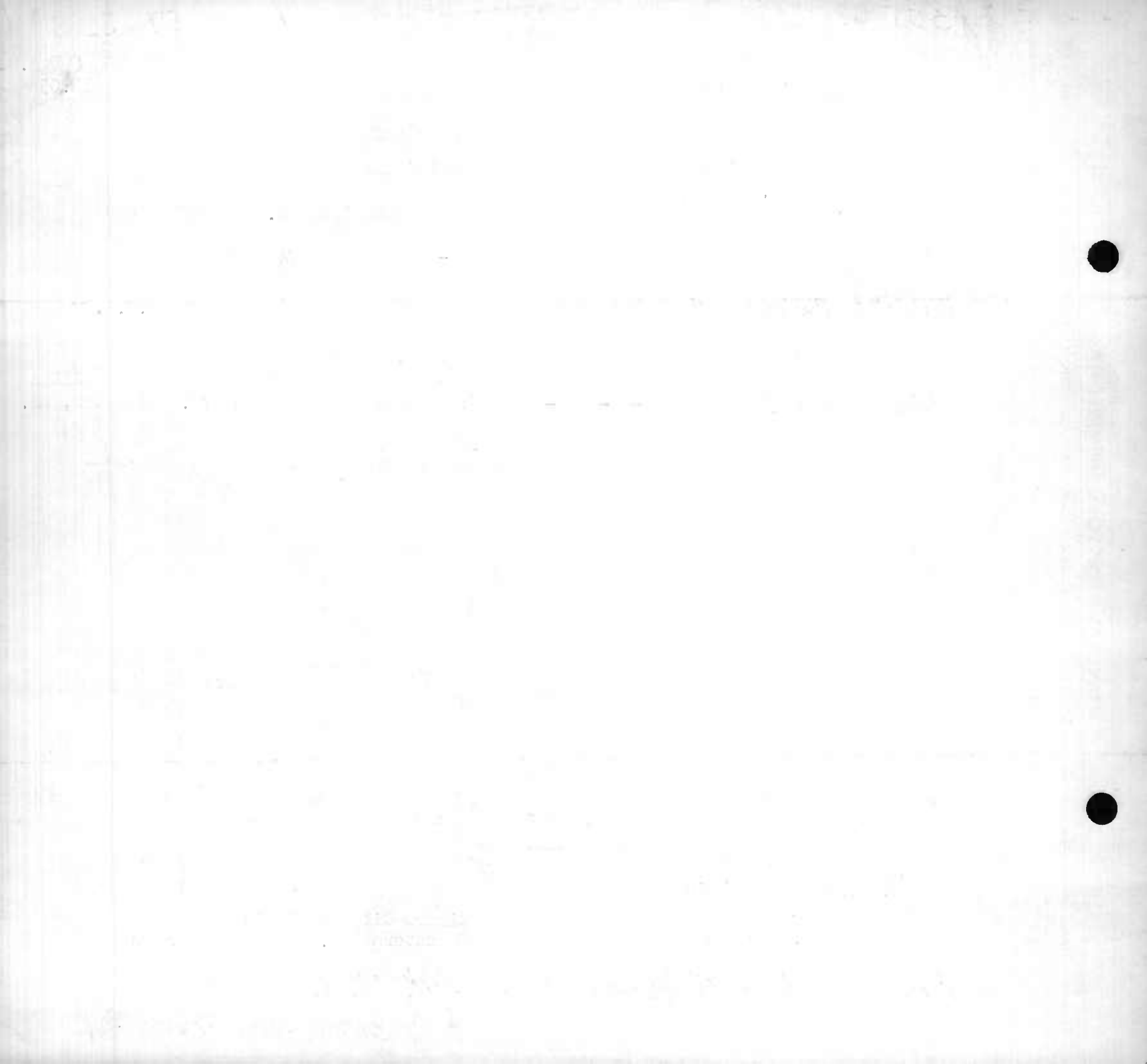
10

Bureau of the Census
Washington, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Fred W. Sittenham		2. DATE AND HOUR OF DEATH 5/24/67 11:05 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 924 Litchfield Rd. 21212 007				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-29-93	9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker			
11. BIRTHPLACE (State or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William Sittenham		
14. MOTHER'S MAIDEN NAME Dora N. Nicks			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 060-28-0646-A		17. INFORMANT ADDRESS #21224 BCH: Records 4940 Eastern Ave. Baltimore, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenia, etc. It means the disease, injury or complication which caused death.) Acute Leukemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH 3 weeks				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 5-22-67 to 5-24-67, that (I) (we) lost saw the deceased alive on 5-24-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE Nicholas J. Fortium				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-24-67		
23C. PHYSICIAN'S NAME (Type) Nichola J. Fortium				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore Maryland #21224				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 26/1967		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Parkville, Md.		
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR John Eugene Stone, Truon, Md.		ADDRESS		



67 5139
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

67 5139

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RUTH PASCAR

2. DATE AND HOUR PRONOUNCED DEAD

May 24, 1967

5:35 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 5418 Lynview Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5418 Lynview Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry Goldiner

14. MOTHER'S MAIDEN NAME

Gertrude Kligman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-14-0008

17. INFORMANT

ADDRESS

Mr. Abraham Pascas, 5418 Lynview Avenue

18.

420.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

(Partial)

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 25, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/26/67

23C. NAME OF CEMETERY or CREMATORY

Anshe Emunah-Aitz Chaim

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 29 1967

24B. NAME OF REGISTRAR

M. D. 68 / F. D. 100

24C. FUNERAL DIRECTOR

Sgt. Levinson & Bros. Inc., 6010 Reisterstown

ADDRESS

WALSH & PROFFER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE HAS BEEN RELEASED ON APPROVAL BY DR. FISHER MED. EXAMINER OF BALTIMORE

BIRTH NO. 67 5140		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5140	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print)			2. DATE AND HOUR OF DEATH		
Dr. Samuel Novey			May 23 1967 2.55 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE		
			B. COUNTY		
THE JOHNS HOPKINS HOSPITAL			MARYLAND		
33			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE		
D. STREET ADDRESS (If rural, give location)			19 WEST COLD SPRING LANE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE	MARRIED	12-1-11	55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Physician Psychiatrist				Rocky Mount, North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
ABRAHAM NOVEY		BETSY O BOLER		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		UNKNOWN		DR. RIVA NOVEY, 19 W. COLD SPRING LANE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II			Interval between ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			1 hour		
			Strong Fam. History of coronary artery disease		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		YES	YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from May 23 19 67 to May 23 19 67, that (I) (we) last saw the deceased alive on May 23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Ashley T Haase			5/23/67		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Ashley T Haase			JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
CREMATION	5/26/67	LOUDON PARK	BALTIMORE, MARYLAND		
25A. DATE RECEIVED BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR			
MAY 29 1967	Robert E. Taylor	SOL LEVINSON & BROS. INC., 6010 REIST., RD.			

Letter from Julius Novey, attorney at Law
6-6-67 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 67 5141					CERTIFICATE OF DEATH					Registered No. 67 5141						
1. NAME OF DECEASED (Type or Print) SCHWARTZ, FRANCIS HENRY										2. DATE AND HOUR OF DEATH 5-24-67 1:25 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 SR. AGNES HOSPITAL WILKENS & CATON AVSS. BALTO. 29, MD.										4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY HOWARD Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT, CITY 63-00 D. STREET ADDRESS (If rural, give location) 2 HICKORY DRIVE						
5. SEX MALE		6. RACE CAUCASION		7. MARRIED, NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED		8. DATE OF BIRTH 06-27-94		9. AGE (In years last birthday) 72		10. Under 1 Yr. Months: _____ Days: _____		11. Under 24 Hrs. Hours: _____ Min: _____				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST - RET.					10B. KIND OF BUSINESS OR INDUSTRY PHARMACY					11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME UNKNOWN					14. MOTHER'S MAIDEN NAME UNKNOWN											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN					16. SOCIAL SECURITY NO. 212-01-4756		17. INFORMANT ST. AGNES RECORDS: WILKENS & CATON AVES					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1810 I Uremia Ca of Uremia										CAUSE OF DEATH (A) _____ (B) _____ (C) _____					INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II																
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from MAY 20 19 67 to MAY 24 19 67 , that (I) (we) last saw the deceased alive on MAY 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE <i>George S. Patrick</i> M.D.										23B. DATE SIGNED 5-24-67			23C. PHYSICIAN'S NAME (Type) GEORGE S. PATRICK M.D.		23D. ADDRESS ST. AGNES HOSPITAL WILKENS & CATON AVES., BALTO., MD (29)	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 5/27/67		24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL					24D. LOCATION (City, town, or county) (State) BALTIMORE MD.				
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967					25B. NAME OF REGISTRAR <i>Robert E. Farley</i>					25C. FUNERAL DIRECTOR FARLEY-CAVANAUGH					ADDRESS 6601 FREDERICK	

RECEIVED BY THE HENRY

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

12/1/72

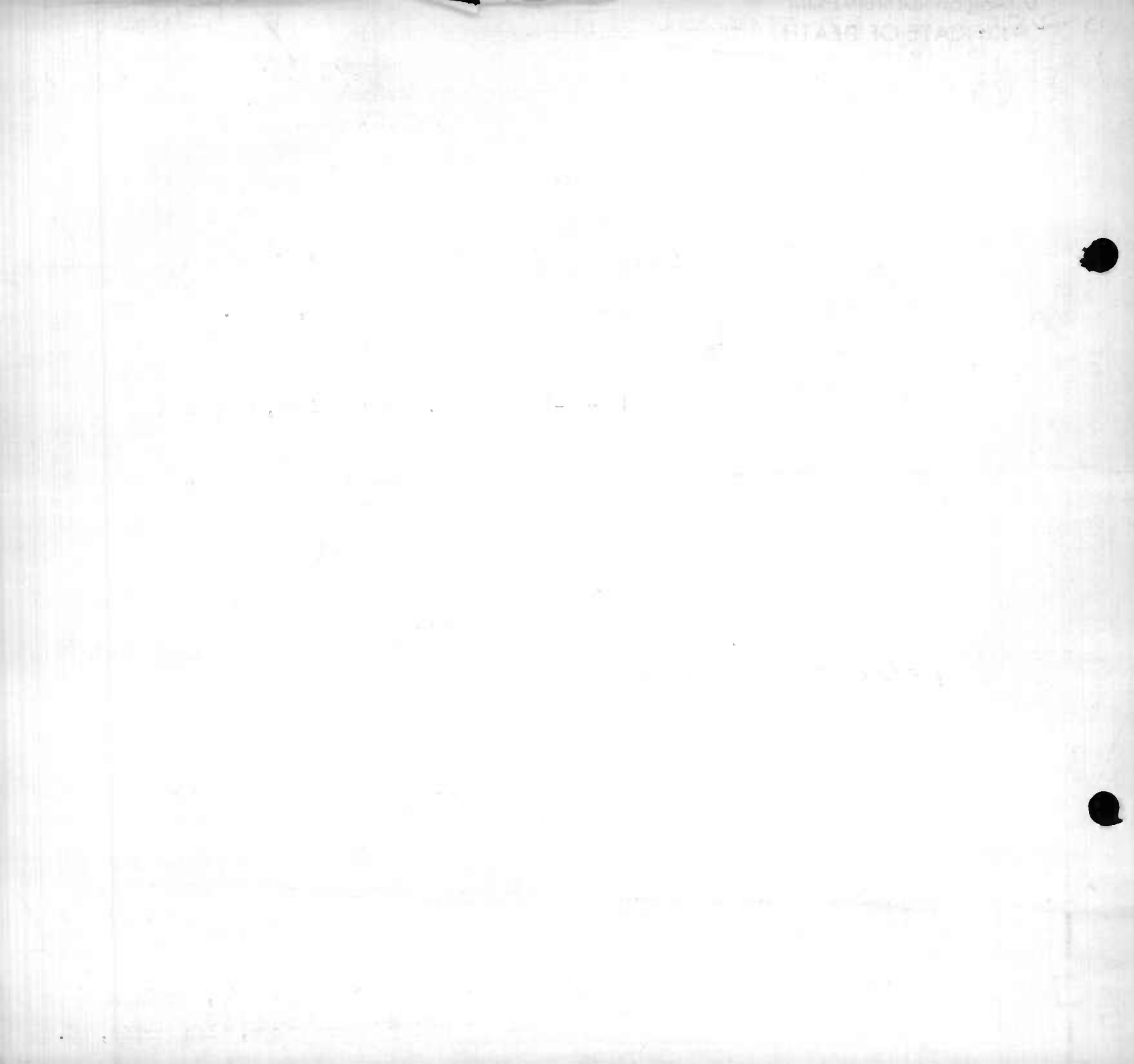
12/1/72

12/1/72

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5142	
BIRTH NO. 67 5142		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SARA A. WAGENMAN		2. DATE AND HOUR OF DEATH 5/24/67 9:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY A. A. C. C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE 52-00 D. STREET ADDRESS (If rural, give location) 105 DORCHESTER RD.		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-02-83	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.	
13. FATHER'S NAME Joseph Rollison			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 166-22-1572		17. INFORMANT Mrs. Howard Snider, same as 4
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Myocardial Infarction (B) Severe Spontaneous Imbalance (C) Acute Cholecystitis		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Spasmodic Cardiac Arrest			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 5/23/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE CHOLECYSTITIS		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/23 19 67 to 5/24 19 67 , that (I) (we) last saw the deceased alive on 5/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Desiderio C. Hebron Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5/24/67	
23C. PHYSICIAN'S NAME (Type) DESIDERIO C. HE BRON JR. M.D.		23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 27 May 67		24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial	
24D. LOCATION Howard County, Maryland		24E. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Farber			



1
A-535

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5143 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5143

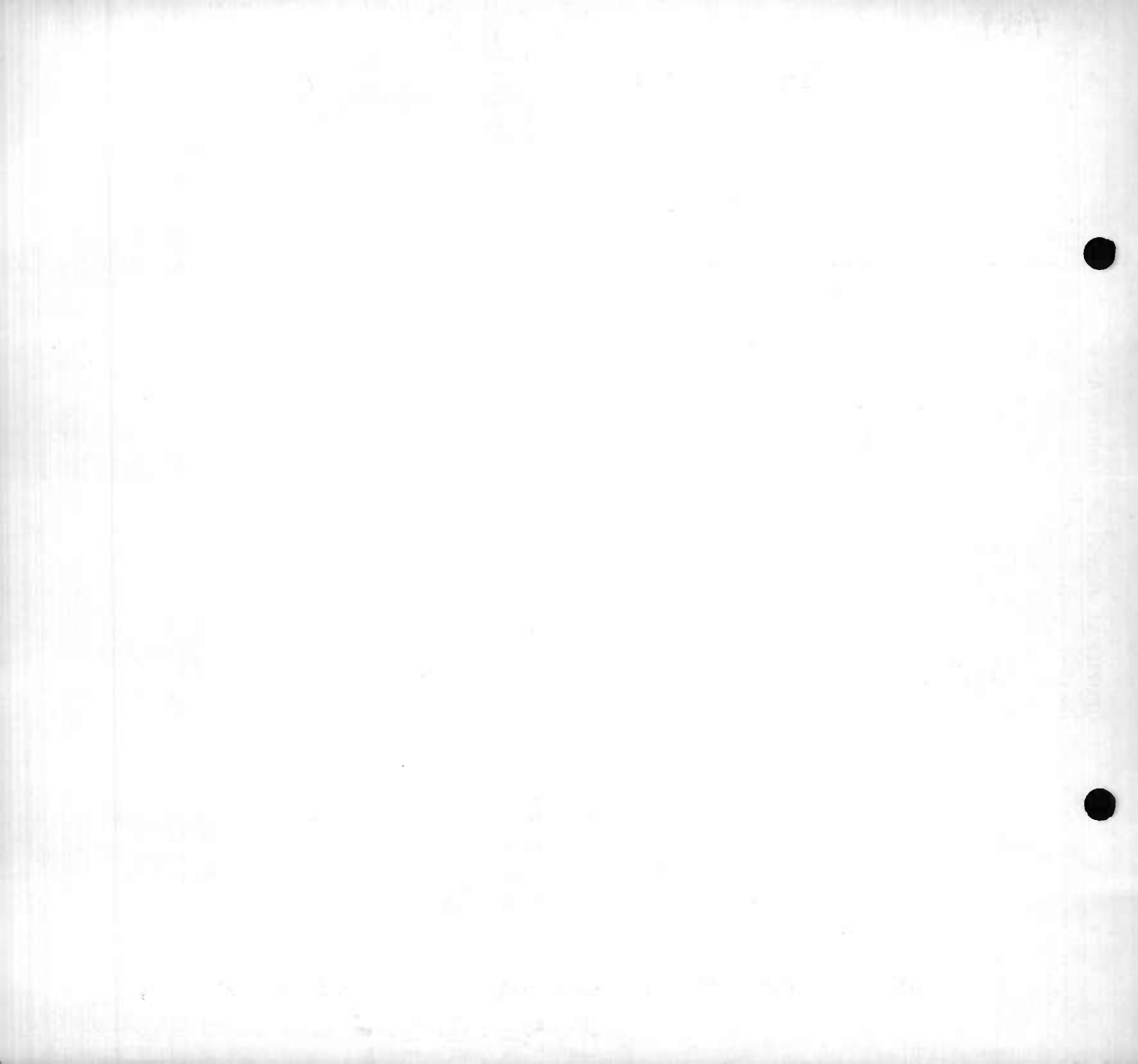
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		JOHN ANTHONY		2. DATE AND HOUR PRONOUNCED DEAD May 25, 1967 8:15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CERTIFICATE AMENDED 00113 North Paca Street 6-21-67				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-01 D. STREET ADDRESS (If rural, give location) 113 N. Paca Street, Room 27	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH Jan 11, 1909	9. AGE (In years lost birthday) 58	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired XXXXXXXX		10B. KIND OF BUSINESS OR INDUSTRY Furniture Finisher Sandler Bros		11. BIRTHPLACE (State or foreign country) Md 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ammon Anthony.		14. MOTHER'S MAIDEN NAME Annie G. Hammond		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no no	
16. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS DeSales Anthony, 1614 E. 25th St			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163X I Carcinoma of lung DUE TO (A) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 25, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5/29/67		23C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		24B. NAME OF REGISTRAR 10226 2730		24C. FUNERAL DIRECTOR Austin C. Donovan - 3818 Roland Ave	
23D. LOCATION Taylor Ave, Md		23E. LOCATION (City, town, or county) (State)			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

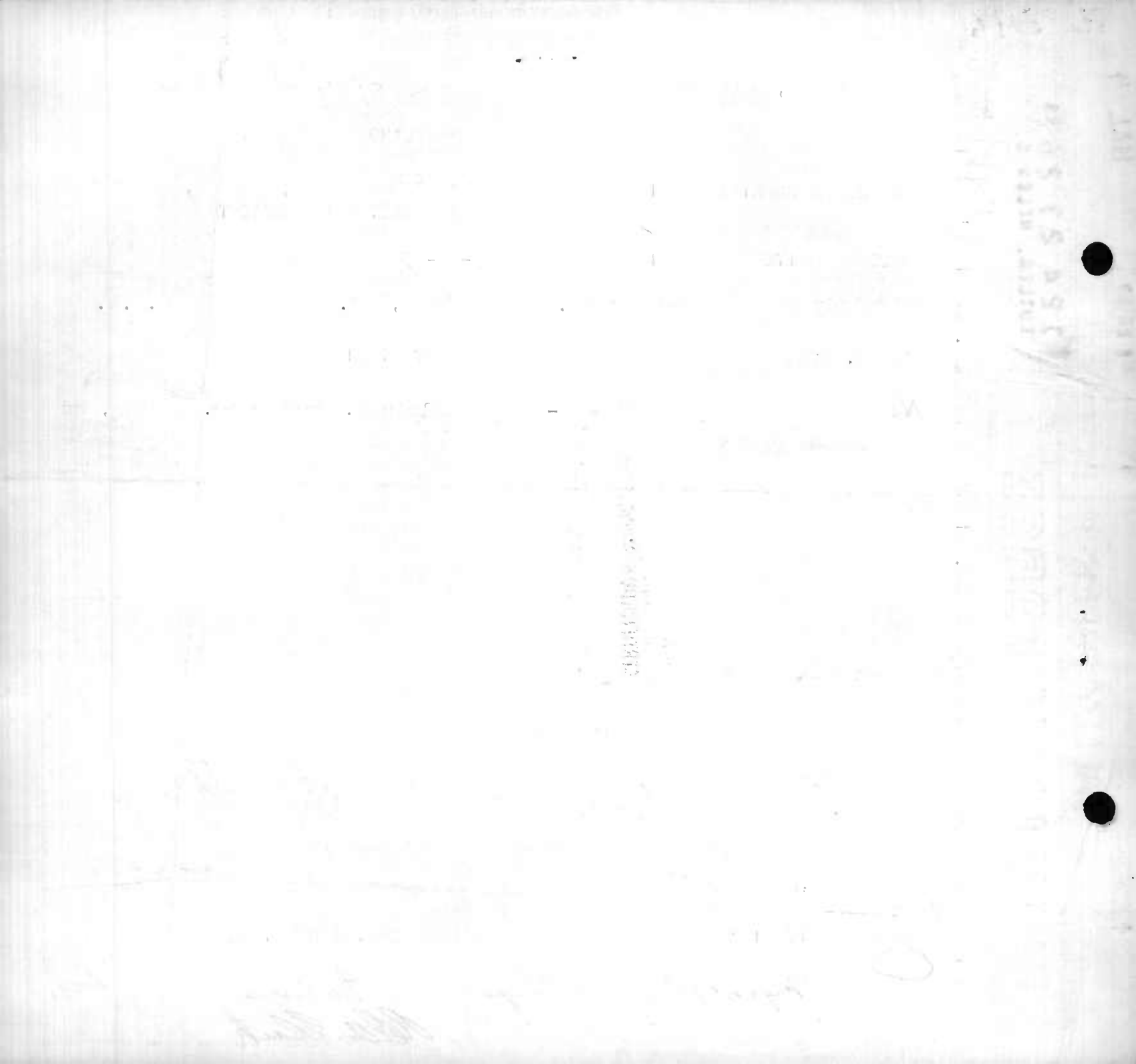
BIRTH NO. 67 5144		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5144	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND/HOUR OF DEATH 25 MAY 1967 14 40 A.M.	
1. NAME OF DECEASED (Type or Print) Althoff, Frida E.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital		A. STATE Md B. COUNTY Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5919 Lillian Ave			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11 Aug 1895	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick Wegar		14. MOTHER'S MAIDEN NAME Anna Poech	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital chart.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Pulmonary Embolus		INTERVAL BETWEEN ONSET AND DEATH Immediate	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO Thrombophlebitis - Iliofemoral 10 days			
		(B) DUE TO ASCVD - Congestive Heart Failure Long Standing			
		(C) Gangrene toe @ Foot			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 11 April 67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ASCVD - Gangrene		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 11 1967 to May 25 1967, that (I) (we) last saw the deceased alive on May 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward D. Layne		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 25 MAY 1967	
23C. PHYSICIAN'S NAME (Type) Edward D. Layne		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) Old Frederick Rd, Md		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Austin E. Donovan - 3818 Roland Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Death by gunshot; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5145					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 5145				
1. NAME OF DECEASED (Type or Print) BUTLER, HELEN BYRD					2. DATE AND HOUR OF DEATH 5/24/67 5:45 AM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND B. COUNTY TALBOT				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) EASTON				
D. STREET ADDRESS (If rural, give location) 308 EAST DOVER STREET					70-29				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 7-22-05	9. AGE (In years lost birthday) 61	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady			10B. KIND OF BUSINESS OR INDUSTRY Drug Store.		11. BIRTHPLACE (State or foreign country) Delmar, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES E. BYRD					14. MOTHER'S MAIDEN NAME MARY GILLIS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 219-0104527		17. INFORMANT Calvin P. Butler Jr. Easton, Md				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO Borne - 2° + 3° of chest neck + thigh					INTERVAL BETWEEN ONSET AND DEATH 4 wk				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None 70-29				
21D. TIME OF INJURY (APPROX.) April		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Smoking in Bed 5:45					
22. I certify that (I) (this hospital) attended the deceased from 4/29 to 5/24 1967, that (I) (we) last saw the deceased alive on 5/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Walter Smithwick					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 5/24	
23C. PHYSICIAN'S NAME (Type) WALTER SMITHWICK					23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL				
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE May 29 1967		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Del		
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR John E. Tolson			25C. FUNERAL DIRECTOR John E. Tolson			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5146		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 5146	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) PILLI, DOMINIC				2. DATE AND HOUR OF DEATH MAY 25, 1967 6:00AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO. 29, MD.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. 29 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3152 LEEDS ST.			
5. SEX MALE	6. RACE CAUCASION	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 05-20-94	9. AGE (In years lost birthday) 72 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - LABORER		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - LABORER			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME VINCENT BOX PILLI DEC'D				
14. MOTHER'S MAIDEN NAME AUGUSTA ? DEC'D			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				
16. SOCIAL SECURITY NO. 218-10-4983			17. INFORMANT ADDRESS AVES.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.04-260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Prethoriorobotic DUE TO (B) Heart disease - Congestive Heart failure - Dissecting Aortic DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAY 23, 19 67 to MAY 25, 19 67 , that (I) (we) last saw the deceased alive on MAY 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George Angov M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED MAY 25, 1967	
23C. PHYSICIAN'S NAME (Type) GEORGE ANGOV				23D. ADDRESS M.D. WILKENS & CATON AVES., BALTO. 29, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 29, 1967		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Schab		25C. FUNERAL DIRECTOR G. Truman Schwab		ADDRESS 3512 Frederick Ave., Balto. Md.	

NAME:

JOHN W. SMITH

1000 1st St., N.W.

WASHINGTON, D.C.

2000 1st St., N.W.

WASHINGTON, D.C.

2000 1st St., N.W.

WASHINGTON, D.C.

2000 1st St., N.W.

WASHINGTON, D.C.

2000 1st St., N.W.

WASHINGTON, D.C.

2000 1st St., N.W.

WASHINGTON, D.C.

WASHINGTON, D.C. 2000 1st St., N.W.

2000 1st St., N.W.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

Copied & released by medic examiner to VNH-5/24/67 - David Schwartz, M.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5147		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5147	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BELVA DELL		2. DATE AND HOUR OF DEATH 5/23/67 1 345 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital - 33rd & Calvert Sts		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3342 Old York Rd.			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 5/15/99	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: 8 Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Alexander Sirtz			
14. MOTHER'S MARDEN NAME Maggie Hooper		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E916.0		CAUSE OF DEATH (A) 80% Total Body burn 2nd degree 2 days (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.		MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 None 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) 5-21-67 6:10 PM		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3342 Old York Rd. Y-03 21F. HOW DID INJURY OCCUR? Standing too close to gas heater Dress caught fire	
22. I certify that (this hospital) attended the deceased from 5/21 1967 to 5/23 1967, that (we) lost saw the deceased alive on 5/23 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE David S. Schwartz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/23/67	
23C. PHYSICIAN'S NAME (Type) DAVID S. SCHWARTZ		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-26-67		24C. NAME OF CEMETERY or CREMATORY WESTMINSTER CEM. WESTMINSTER MD.	
24D. LOCATION (City, town, or county) (State) NEW WINDSOR MD.		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR D.D. Huth			

Washington
D.C. 20540
2048-0000

U.S. District Court
2048-0000

For the White
House

2/12/91 08
Washington
D.C. 20540

President's Office

80% total (by law) 2/12/91

2/12/91 08

2/12/91

John A. Bush
John A. Bush

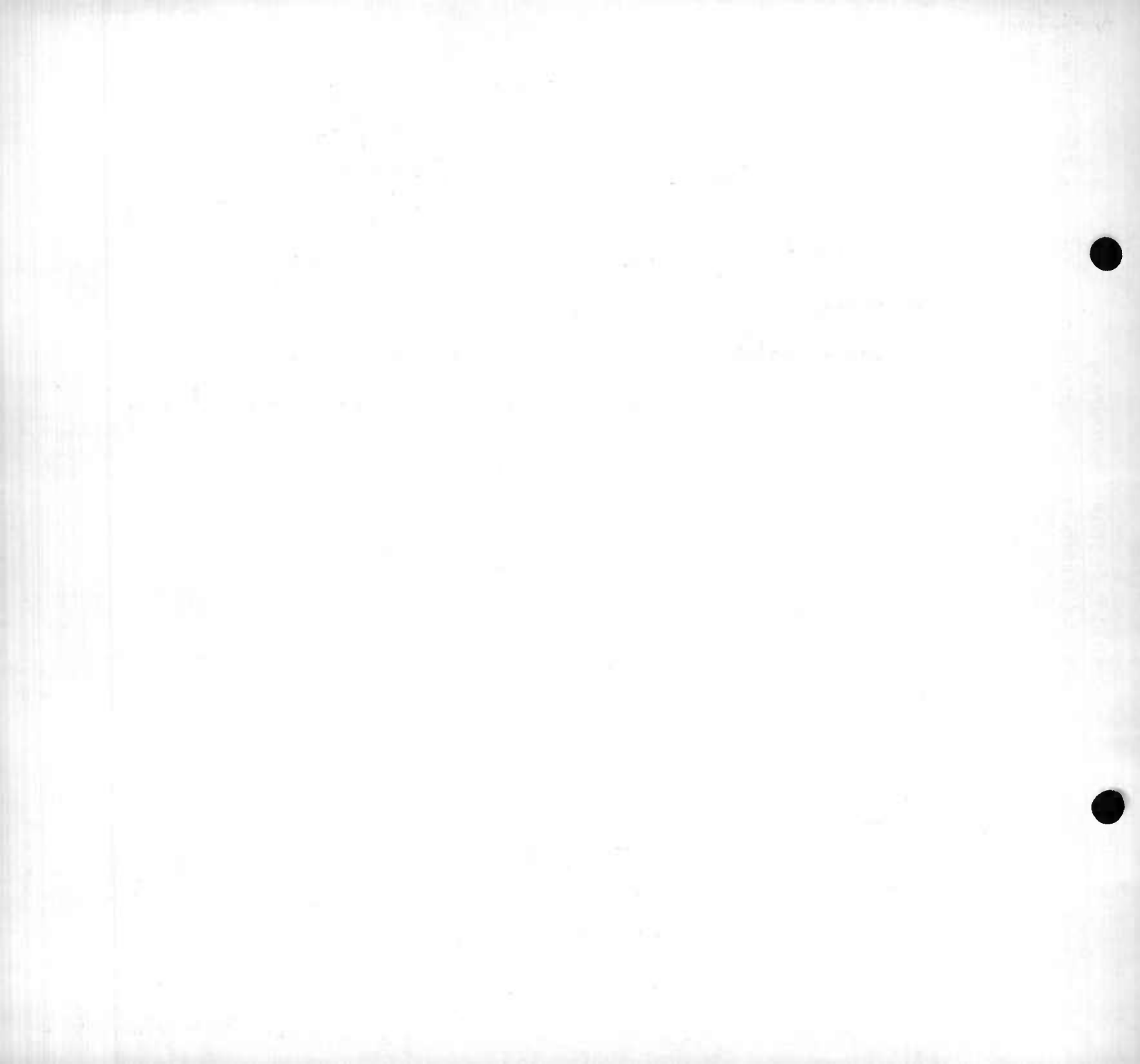
M-650

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5148		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5148	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) CHARLES MORAN		2. DATE AND HOUR PRONOUNCED DEAD May 24, 1967 1:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		A. STATE Maryland B. COUNTY	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-01	
		D. STREET ADDRESS (If rural, give location) 115 W. Saratoga Street	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S.	8. DATE OF BIRTH 3-9-07
9. AGE (In years last birthday) 60		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles E.		14. MOTHER'S MAIDEN NAME Lillian Sullivan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family - Same		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia complicating multiple traumatic injuries		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic pulmonary emphysema		(B) DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fayette and Howard Streets 4-01			
21D. TIME OF INJURY (APPROX.) 4-27-67 2:00 A.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? Pedestrian struck by car			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED May 25, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE 5/29/67	
23C. NAME of CEMETERY or CREMATORY Loudon PK		23D. LOCATION (City, town, or county) (State) Baltimore	
24A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		24B. NAME OF REGISTRAR R. E. Johnson	
24C. FUNERAL DIRECTOR 237 To Tap See 4-2		24D. ADDRESS 25	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

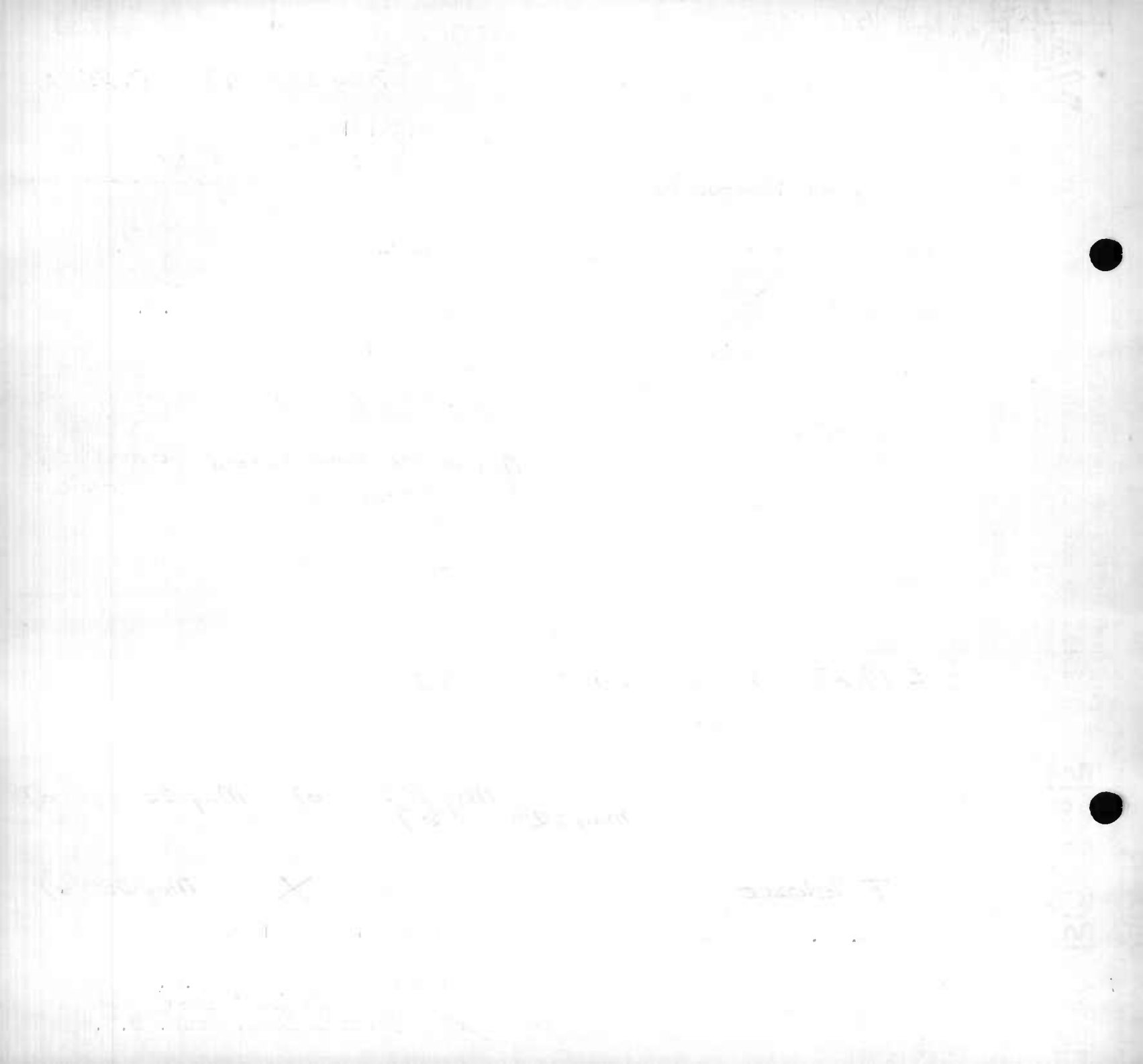
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5149	
BIRTH NO. 67 5149				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John J. Valis (Vales)		2. DATE AND HOUR OF DEATH May 26, 1967 2:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 414 N. DUNCAN ST.		A. STATE Maryland. B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 6-03	
		D. STREET ADDRESS (If rural, give location) 414 N. Duncan St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan 22, 1887	9. AGE (In years' last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY Terminal Warehouse		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Valis		14. MOTHER'S MAIDEN NAME Anne Streckel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-10-5562		17. INFORMANT ADDRESS Mary K. Steiner 414 N. Duncan St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443 X I		CAUSE OF DEATH (A) Cerebral hemorrhage DUE TO (B) Hypertensive C.V.D. DUE TO (C) Atherosclerosis - generalized		INTERVAL BETWEEN ONSET AND DEATH 1 day ? ?	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/6 1966 to 5/26 1967 , that (I) (we) last saw the deceased alive on 5/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Louis F. Klimes		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/26/67	
23C. PHYSICIAN'S NAME (Type) LOUIS F. KLIMES		23D. ADDRESS M.D. 2623 E. Monument St 21205			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery Baltimore Md.	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Philip E. Bailey	
25C. FUNERAL DIRECTOR Philip E. Bailey		25D. ADDRESS 1211 Chesapeake Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

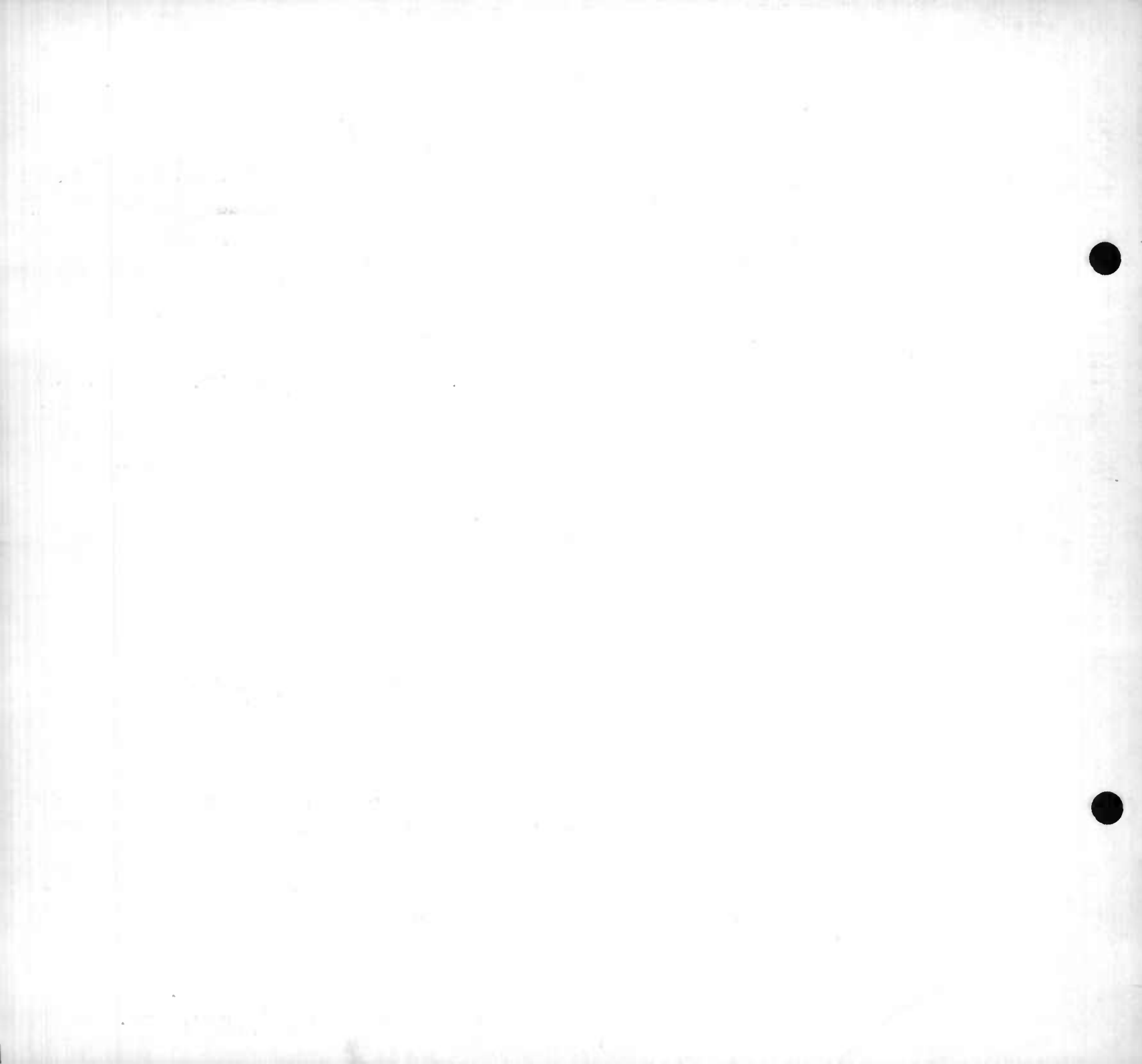
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 5150				
BIRTH NO. 67 5150					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) RICHARD HOLLERITH					2. DATE AND HOUR OF DEATH May 23 rd 1967 10:25 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL					A. STATE VIRGINIA				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) QUINBY V-43				
					D. STREET ADDRESS (If rural, give location) Warwick Farm				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-28-1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME HERMAN HOLLERITH			14. MOTHER'S MAIDEN NAME LUCIA TALCOTT						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 149 12 0749		17. INFORMANT Mrs. Helen Faquherson Hollerith, above				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1930 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Glioma of right cerebral hemisphere. (B) DUE TO (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 6 months or more.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 5-17-67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 10 th 19 67 to May 23 19 67. that (I) (we) last saw the deceased alive on May 22 nd 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE F. Velasco						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 23 rd 67	
23C. PHYSICIAN'S NAME (Type) DR. F. VELASCO						23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 24, 1967		24C. NAME OF CEMETERY or CREMATORY Oak Hill Cemetery,		24D. LOCATION (City, town, or county) (State) Washington, D.C.			
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			25B. NAME OF REGISTRAR Robert E. Farley, M.D.			25C. FUNERAL DIRECTOR H. Hon. DeVol			
ADDRESS DeVol Funeral Home, Wash. D.C.									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5151	
BIRTH NO. 67 5151				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>LILLIAN H. HOOK</i>			2. DATE AND HOUR OF DEATH <i>5-25-67 6:20 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3606 Erdman Avenue</i>		
5. SEX <i>Fe</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>3/03/92</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Michael Strohmee</i>			14. MOTHER'S MAIDEN NAME <i>Rosalba Hoffman</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-09-6560D</i>	17. INFORMANT <i>Mrs. Dorothy Steer, dght.</i>		ADDRESS <i>21229 Pk Chart 726 Charing Cross Rd.</i>
18. <i>581.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>hepatic coma</i> DUE TO (B) <i>Postneurotic syndrome</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>?</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/5/67</i> 19 <i>67</i> to <i>May 25</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>5/25</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A.H. Ghiladi</i>				23B. DATE SIGNED <i>May 25/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Abdolhamid Ghiladi</i>		23D. ADDRESS <i>Bon Secours Hospital.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>5/27/67</i>	24C. NAME of CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 29 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> <i>3331 Brehms Lane</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

THIS CASE HAS BEEN RELEASED ON APPROVAL BY DR. SPRINGATE, OF M.E. OFFICE OF CITY OF BALTIMORE

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 5152		67 5152	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		EFFIE G. HAMILTON		2. DATE AND HOUR OF DEATH 5-25-67 1.55 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND			
THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
33		D. STREET ADDRESS (If rural, give location) 955 N. WASHINGTON STREET 21205			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 1-18-89	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME SAMUEL STONE			
14. MOTHER'S MAIDEN NAME Mary S. Jenkins		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
213-28-889D		16. SOCIAL SECURITY NO.			
17. INFORMANT Helen Rusk, dght. above		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 331X I CEREBROCRANIAL INJURIES CVA		INTERVAL BETWEEN ONSET AND DEATH one day		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 955 N. WASHINGTON ST.	
21D. TIME OF INJURY (APPROX.) 5-24-67 9:10 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL AT HOME	
22. I certify that (1) (this hospital) attended the deceased from 5/24/67 to 5/25/67, that (1) (we) lost saw the deceased olive on 1:40 am 5/25/67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tgh-Hsiung Hsu		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/25/67	
23C. PHYSICIAN'S NAME (Type) TAH-HSILUNG Hsu		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR R. E. Fidler		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			

on 9/2

CA

we

Wen

2/2

2/2

2/2

0

TAH-Hsing Han
Tah-Hsing Han

X
The John Taylor

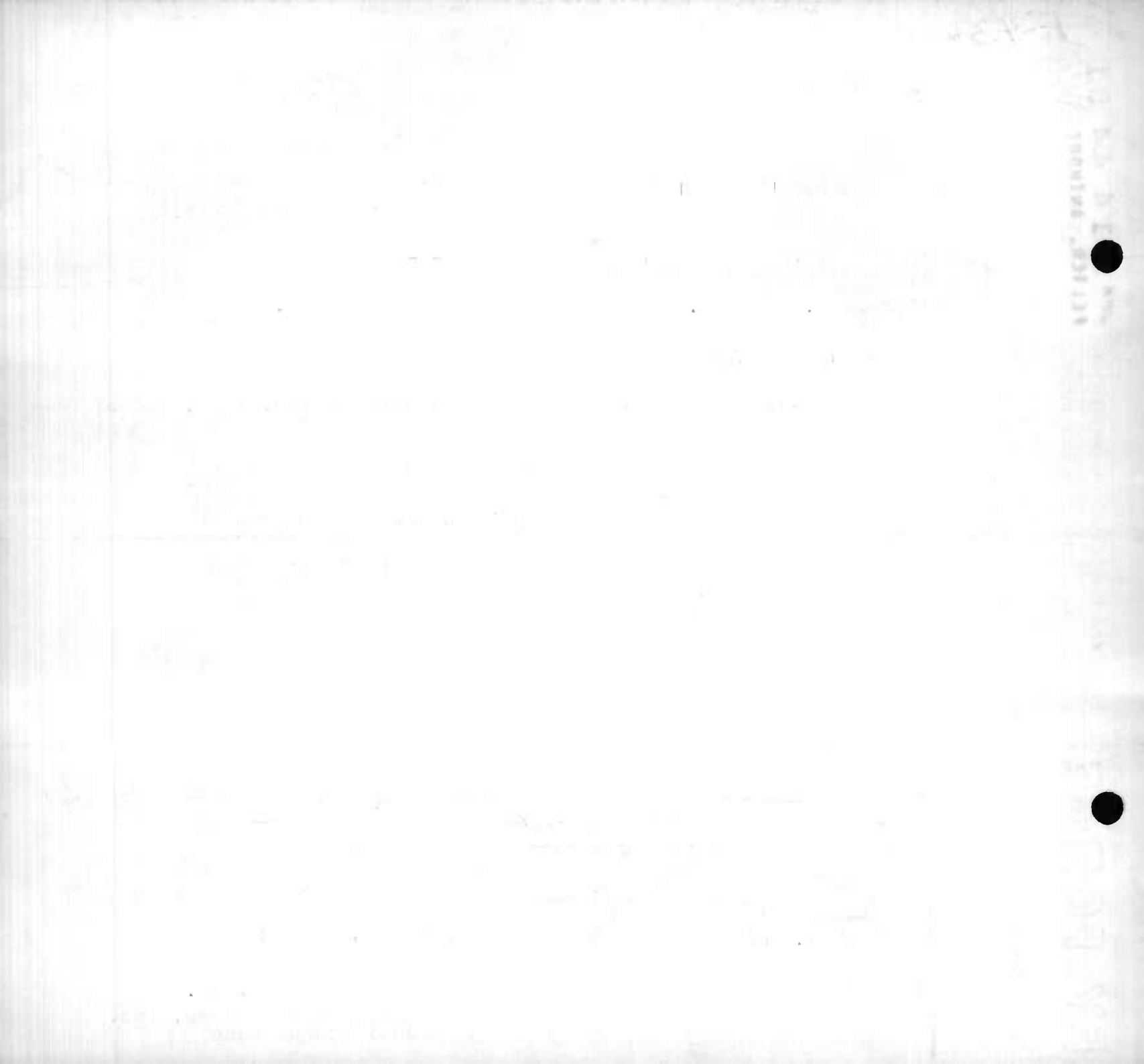
2/2/01

FUNERAL DIRECTOR: IMPORTANT

JUN 14 44 81

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5153	
1. NAME OF DECEASED (Type or Print) <u>Felter, Anthony</u>		2. DATE AND HOUR OF DEATH <u>5/26/67</u> <u>9:00 A.</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>7-03</u> D. STREET ADDRESS (If rural, give location) <u>724 NORTH PATTERSON PARK AVENUE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-9-05</u>	9. AGE (In years lost birthday) <u>61</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police Dept.</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>CHRISTIAN FELTER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA WITTIG</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW2-army</u>		16. SOCIAL SECURITY NO. <u>219-03-3355</u>		17. INFORMANT ADDRESS <u>Emma Wick Felter, wife, above</u>			
18. <u>150 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Aspiration pneumonia</u> (A) DUE TO <u>carcinoma of esophagus</u> (B) DUE TO <u>carcinoma of esophagus</u> (C) DUE TO <u>carcinoma of esophagus</u>				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2 none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4 AM</u> <u>5/26</u> 19 <u>67</u> to <u>9 AM</u> <u>5/26</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/26/67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Floyd T Bryan</u> M.D.				23B. DATE SIGNED <u>5/26/67</u>		23C. PHYSICIAN'S NAME (Type) <u>FLOYD T. BRYAN</u>	
23D. ADDRESS M.D. <u>JOHNS HOPKINS HOSPITAL</u>				23E. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/29/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 29 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Schimunek</u>		25C. ADDRESS <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5154				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5154	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALVERTA RUSSELL				2. DATE AND HOUR OF DEATH 21 May 67 9 40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIV of MARYLAND Hosp				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY Calvert Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Prince Frederick 5400 D. STREET ADDRESS (If rural, give location) ?			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5/6/18	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H/W		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WM I. RUSSELL			14. MOTHER'S MAIDEN NAME HELEN STEWART				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. -		17. INFORMANT Chart ADDRESS		
18. 757.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Renal Failure DUE TO (B) Polycystic Kidney Disease DUE TO (C) and Klebsiella septicemia		INTERVAL BETWEEN ONSET AND DEATH about 1 year life 1 week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 17 May 19 67 to 21 May 19 67 , that (I) (we) last saw the deceased alive on 21 May 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stanley Music				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 21 May 67	
23C. PHYSICIAN'S NAME (Type) STANLEY MUSIC		23D. ADDRESS M.D. 90 UNIV Hosp					
24A. BURIAL CREMATION, REMOVAL (Specify) Y		24B. DATE 5-25-67		24C. NAME OF CEMETERY or CREMATORY Mt. Oliver Ch. Cem.		24D. LOCATION (City, town, or county) (State) Prince Frederick Cal. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Pinkney E. Sewell ADDRESS Prince Frederick Md			

of the ...

...

...

Chart

...

...

...

...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5155	
BIRTH NO. 67 5155		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRED HOLMES		2. DATE AND HOUR OF DEATH 5/26/67 12:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital 39 Baltimore, Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #17 15-01			
		D. STREET ADDRESS (If rural, give location) 1632 GILMORE ST.			
5. SEX M.	6. RACE C.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 20, 1915	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Electric Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Holmes			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 249-01-5814		17. INFORMANT Rosella Holmes ADDRESS 1632 GILMORE ST.	
18. 443 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest		CAUSE OF DEATH (A) DUE TO Hypertension (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 10 A.M. May 25 1967 to May 26, 12:30 A.M. 1967 , that (I) (we) last saw the deceased alive on 11:30 P.M. 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. R. G. Ramani M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5/26/67	
23C. PHYSICIAN'S NAME (Type) A. G. RAMANI M.D.				23D. ADDRESS The Provident Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-67		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR R. E. F. F. F.		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. ADDRESS 1735 Harford Avenue	



1
w-656

67 5156
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5156

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HELEN WALKER Warner 2. DATE AND HOUR PRONOUNCED DEAD May 24, 1967 3:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 663 W. Mulberry Street C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-02

D. STREET ADDRESS (If rural, give location) 663 W. Mulberry Street

5. SEX Female 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W 8. DATE OF BIRTH 6/10/83 9. AGE (in years last birthday) 86

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Benjamin Curtis 14. MOTHER'S MAIDEN NAME Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS Mrs Helen Taylor, Glen Burnie Md

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease (A) DUE TO (B) DUE TO (C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER DATE SIGNED May 25, 1967 EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

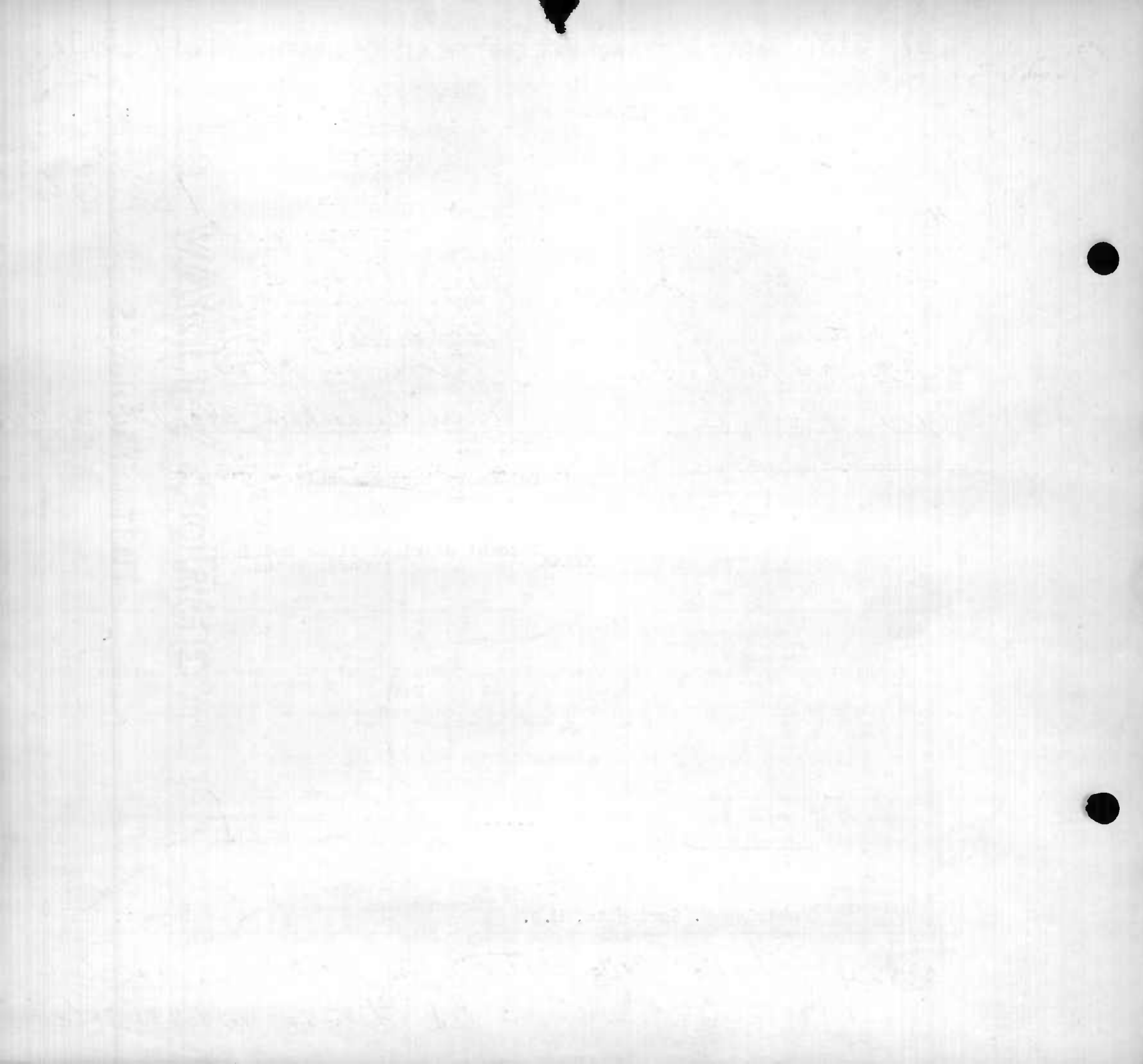
23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 5/28/67 23C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery 23D. LOCATION (City, town, or county) (State) A A County Md

24A. DATE REC'D BY HEALTH DEPT. MAY 29 1967 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave

WALSH & GORRIS

1
R-263

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO. 67 5157		M.E. CASE NO.		Registered No. 67 5157			
1. NAME OF DECEASED (Type or Print) THOMAS RICHARDSON				2. DATE AND HOUR PRONOUNCED DEAD May 25, 1967 2:43 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46/99 Luthern Hospital (DOA)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-66 D. STREET ADDRESS (If rural, give location) 2937 Walbrook Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH March 18, 1932	9. AGE (In years last birthday) 35	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Richardson				14. MOTHER'S MAIDEN NAME Elsie Tucker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Elsie Richardson 2937 Walbrook Ave			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary thromboemboli (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Thrombi of right iliac and left femoral veins (B) XXXXX (C)				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 26, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5/31/67		23C. NAME of CEMETERY or CREMATORY Baltimore National Cem		23D. LOCATION (City, town, or county) (State) Baltimore Maryland	
24A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		24B. NAME OF REGISTRAR Robert E. Farber		24C. FUNERAL DIRECTOR Earl Gilmore		ADDRESS 1827 W North Ave	



R-152

67 5158

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5158

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

May 25, 1967

7:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED

36

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1029 Sarahann Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

June 12, 1903

9. AGE (in years
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Char Woman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

A.A. Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Benjamin Hebron

14. MOTHER'S MAIDEN NAME

Maggie Hammond

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

812-14-3075

17. INFORMANT ADDRESS

Annie Thomas Laurel Md.

18.

E 8124

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Pulmonary thromboembolus
complicating fractures of the right
tibia and fibula

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Hypertensive and arteriosclerotic
cardiovascular diseaseINTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Saratoga at Schroeder Streets

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5-21-67 9:50 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by car

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 25, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

May 28, 1967

23C. NAME OF CEMETERY or CREMATORY

Mt Zion Methodist

23D. LOCATION

(City, town, or county)

(State)

Laurel Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 29 1967

24B. NAME OF REGISTRAR

R. E. Taylor

24C. FUNERAL DIRECTOR

Williams Funeral Home 3197 Schroeder St

ADDRESS

Letter from Dr. Charles S. Springate, Asst. M.E. dated 6/15/67

1
4-252 67 5159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5159

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Edward L. EDWOOD HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

1:22 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

? 619 S. Paca St.

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12/26/35

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

James Hawkins

14. MOTHER'S MAIDEN NAME

Ella Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lucy Silver 619 S. Paca St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of abdomen
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Tavern

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Ace High Tavern

652 W. Conway Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 26 '67 9:00 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-27-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/1/67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 29 1967

R. S. Fisher, M.D.

Charles A. Rice 661 W. Barre St.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 5160**

BIRTH NO. 67 5160

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **JOSEPH R DZERZINSKI**

2. DATE AND HOUR PRONOUNCED DEAD **5-26-67** **5:00 PM M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **809 S. MONTFORD AVENUE - Amb. Crew #10**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY **Baltimore**

5. SEX **Male** **6. RACE** **White** **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)** **NEVER MARRIED**

8. DATE OF BIRTH **JULY 27, 1927** **9. AGE (In years last birthday)** **39**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **10B. KIND OF BUSINESS OR INDUSTRY** **LONGSHOREMAN**

11. BIRTHPLACE (State or foreign country) **PENNSYLVANIA** **12. CITIZEN OF WHAT COUNTRY?** **U.S.**

13. FATHER'S NAME **JOSEPH DZERZINSKI** **14. MOTHER'S MAIDEN NAME** **SOPHIA STEFANOWICZ**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **YES KOREA**

16. SOCIAL SECURITY NO. **195-20-1495** **17. INFORMANT** **LEONARD DZERZINSKI** **ADDRESS** **809 S, MONTFORD**

18. CAUSE OF DEATH
I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
Laennec's cirrhosis with fatty metamorphosis
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **20A. AUTOPSY? (Yes or No)** **Yes** **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?** **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** **21F. HOW DID INJURY OCCUR?**

22. I certify that I held on **Inquiry** **Inspection** **Autopsy** **X** **and that on this basis, death in my opinion resulted from:** **Natural causes** **X** **Accident** **Suicide** **Homicide** **Undetermined manner**

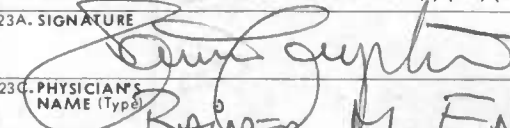
ACTUAL SIGNATURE **RUSSELL S. FISHER, M.D.** **CHIEF MEDICAL EXAMINER** **X** **DATE SIGNED** **5-27-67**

23A. BURIAL CREMATION, REMOVAL (Specify) **BURIAL** **23B. DATE** **MAY 31, 1967** **23C. NAME of CEMETERY or CREMATORY** **HOLY ROSARY CEMETERY** **23D. LOCATION** (City, town, or county) (State) **BALTIMORE MARYLAND**

24A. DATE REC'D BY HEALTH DEPT. **MAY 29 1967** **24B. NAME OF REGISTRAR** **John A. Fisher** **24C. FUNERAL DIRECTOR** **JOHN A. BEBER & SONS INC.** **ADDRESS** **401 SOUTH CHESTER STREET**

Letter re correction from Dr.R.S.Fisher-dated June 10,1967

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5161	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5161 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) DUL, JOSEPH			2. DATE AND HOUR OF DEATH 5-27-67 18³⁰ P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE City 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE City 6-02 6. STREET ADDRESS (If rural, give location) 206 N PORT ST		
5. SEX M	6. RACE CAN W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-19-90	9. AGE (In years last birthday) 77	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BETH. STEEL
11. BIRTHPLACE (State or foreign country) POLAND			12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME FRANK DUL			14. MOTHER'S MAIDEN NAME REGINA KRAWICE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-10-5039A	17. INFORMANT MARY DUL 206 N. PORT ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) UREMIA			INTERVAL BETWEEN ONSET AND DEATH ≈ 24 WEEKS		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. METASTATIC CA BLADDER ≈ 4 YRS			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II		
19A. DATE OF OPERATION 12-2-66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA BLADDER	20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-24</u> 19<u>67</u> to <u>MAY 27</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>5-27-19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D.			23B. DATE SIGNED 5-27-67		23C. PHYSICIAN'S NAME (Type) Rainer M. Engel M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 5-31-67		24C. NAME OF CEMETERY or CREMATORY HOLY CROSS POLISH NAT.
24D. LOCATION (City, town, or county) (State) DUNDALK MARYLAND			25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		
25B. NAME OF REGISTRAR Robert E. Johnson			25C. FUNERAL DIRECTOR JOHN M WEBER & SONS INC		
ADDRESS 401 S. CHESTER ST					

4.

1
G. 650

67 5162

BALTIMORE CITY HEALTH DEPARTMENT

67 5162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MADELINE GREEN

2. DATE AND HOUR PRONOUNCED DEAD

5-24-67 12:20 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1320 N. BRUCE STREET - Amb. Crew #4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1320 N. Bruce Street 21217

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11-30-1920

9. AGE (In years last birthday)

47

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Bell

14. MOTHER'S MAIDEN NAME

Daisy Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Wm Green 1320 Bruce St

18. 443X1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-24-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

5/29/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cem

23D. LOCATION (City, town, or county) (State)

A.A. Co. Md

24A. DATE REC'D BY HEALTH DEPT.

MAY 29 1967

24B. NAME OF REGISTRAR

R. E. Fisher

24C. FUNERAL DIRECTOR

Rayner Sanders

24D. ADDRESS

217 E Preston St

55% (RND) CONTENT

TECHNICAL

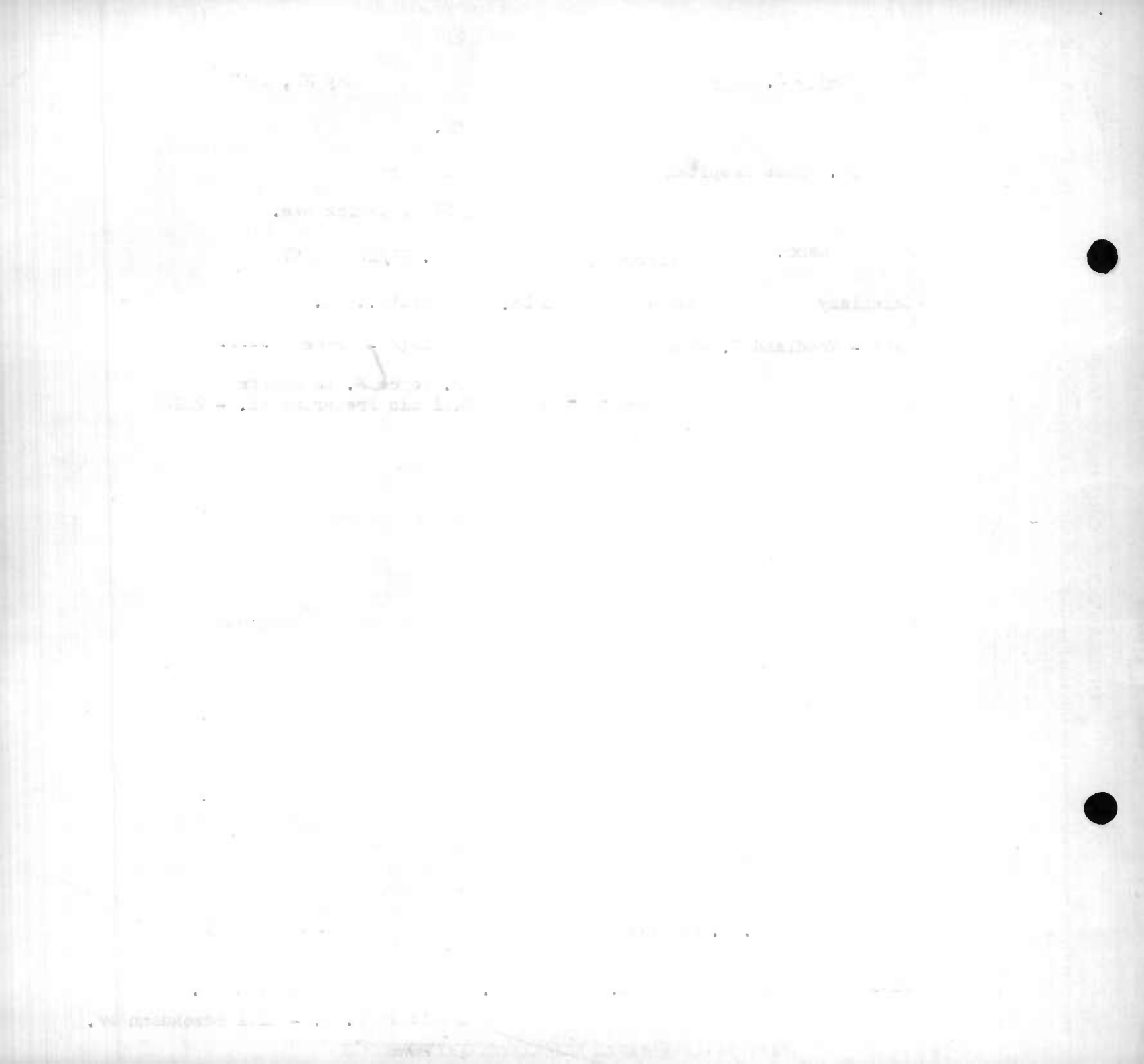
27

27 12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5163	
BIRTH NO. 67 5163		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Emily J. Longshore		2. DATE AND HOUR OF DEATH May 27, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 25-31			
5. SEX F		6. RACE Cauc.		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10B. KIND OF BUSINESS OR INDUSTRY Hochschild Kohn Co.		8. DATE OF BIRTH Feb. 22/10	
13. FATHER'S NAME Late - Woodland W. Walston		14. MOTHER'S MAIDEN NAME Late - Grace		9. AGE (In years last birthday) 57	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-20-5338		17. INFORMANT Mr. Boyce M. Longshore	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 422.1x-260x Pulmonary Thrombosis		CAUSE OF DEATH (A) DUE TO Cardio-Vascular disease		INTERVAL BETWEEN ONSET AND DEATH Sudden	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) DUE TO		(C) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus (controlled)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1929 to May 27 1967 , that (I) (we) last saw the deceased alive on May 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eliot W. Johnson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/27/67	
23C. PHYSICIAN'S NAME (Type) E. W. Johnson		23D. ADDRESS 3437 Frederick Ave Baltimore MD 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/30/67		24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cem.	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR R. E. Johnson		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Av.	



FUNERAL DIRECTOR: IMPORTANT

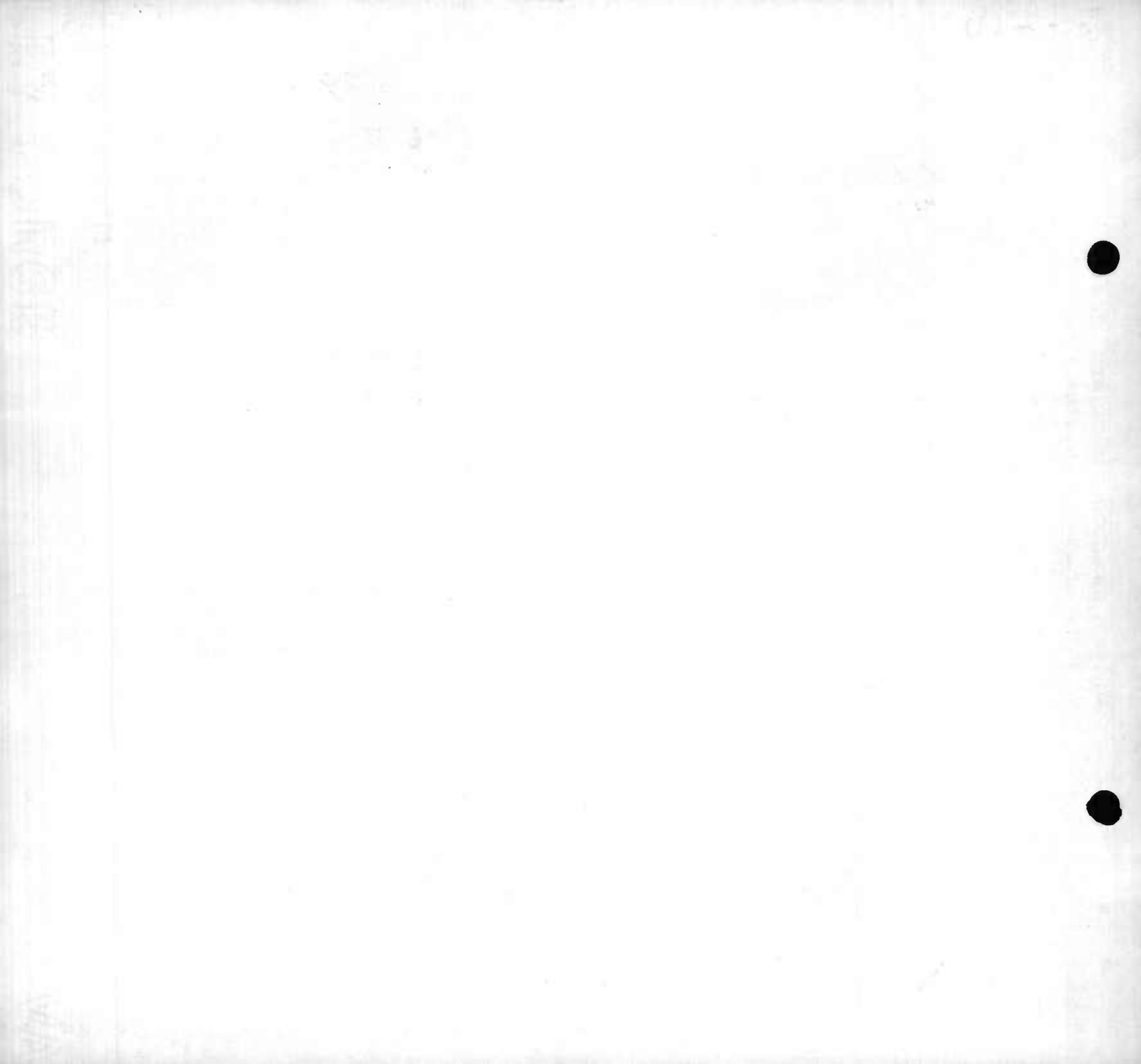
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5164	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5164 CERTIFICATE OF DEATH </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) GRETCHEN HINTZE BEHN			2. DATE AND HOUR OF DEATH 5/26/67 1655 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital Baltimore, Md.			A. STATE MD. B. COUNTY 5600 N. CHARLES ST		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - 21210, MD		
			D. STREET ADDRESS (If rural, give location) 5600 N. Charles St. 27-12		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED (specify)	8. DATE OF BIRTH 12/20/91	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Herman Knollenberg			14. MOTHER'S MAIDEN NAME ---		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. George Mann 914 Montpelier Ave. - 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410X I PULMONARY EMBOLUS DUE TO RHEUMATIC MITRAL STENOSIS & INSUFFICIENCY			INTERVAL BETWEEN ONSET AND DEATH 3 WKS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/66 19 to 5/26 19 67 , that (I) (we) last saw the deceased alive on 5/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis J. Borges				23B. DATE SIGNED 5/26/67	
23C. PHYSICIAN'S NAME (Type) FRANCIS J. BORGES M.D.				23D. ADDRESS UNIVERSITY HPTL, BALTIMORE, MD.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR R. B. E. G. G. G.		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5165	
BIRTH NO. 67 5165		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WILLIAM RIGSBY			2. DATE AND HOUR OF DEATH 5/29/67 6:40 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 19-04 D. STREET ADDRESS (If rural, give location) 1608 W HOLLINS ST.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8/25/1913	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KENTUCKY	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HENRY RIGSBY			14. MOTHER'S MAIDEN NAME LULA HURST		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES #2		16. SOCIAL SECURITY NO. 302034939		17. INFORMANT VIOLET RIGSBY 1608 W HOLLINS ST.	
18. CAUSE OF DEATH A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. C. INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 5/20		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/20 19 67 to 5/30 19 67 , that (I) (we) last saw the deceased alive on 5/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Incluz				23B. DATE SIGNED 5/30/67	
23C. PHYSICIAN'S NAME (Type) DR. KRAVITZ		23D. ADDRESS FRANKLIN SQUARE HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 1-67		24C. NAME OF CEMETERY, or CREMATORY Balto National	
24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR R. E. E. Taylor		25C. FUNERAL DIRECTOR Shirley J. Kenney Inc Balto Md			
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5166				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 67 5166		
1. NAME OF DECEASED (Type or Print) RAY RUSSELL				2. DATE AND HOUR OF DEATH 26 MAY '67 1 64¹ A-M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Tennessee B. COUNTY Jonesboro C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-39 D. STREET ADDRESS (If rural, give location) Pine Street						
5. SEX M	6. RACE Can	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Div	8. DATE OF BIRTH 7/18/20	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? U.S. A.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Tennessee			12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME George Russell				14. MOTHER'S MAIDEN NAME Jane Dickson						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. 11			16. SOCIAL SECURITY NO. 414-07-9819		17. INFORMANT ADDRESS Wayne Alexander F.D. Jonesboro, Tenn.					
18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Sebor pneumonia, RM & RL - lungs				CAUSE OF DEATH (A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO						
(C) DUE TO										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (X) (this hospital) attended the deceased from 26 MAY 1967 to 26 MAY 1967 , that (X) (we) lost saw the deceased alive on 26 MAY 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.										
23A. SIGNATURE William E. Lauder MD				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 27 May '67		
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS Mercy Hospital						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/30/67		24C. NAME of CEMETERY or CREMATORY Maple Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Jonesboro, Tenn.				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Farkner		25C. FUNERAL DIRECTOR Wm Cook-Brooks Inc.		ADDRESS 1217 St Paul & Preston				

7-29-13

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

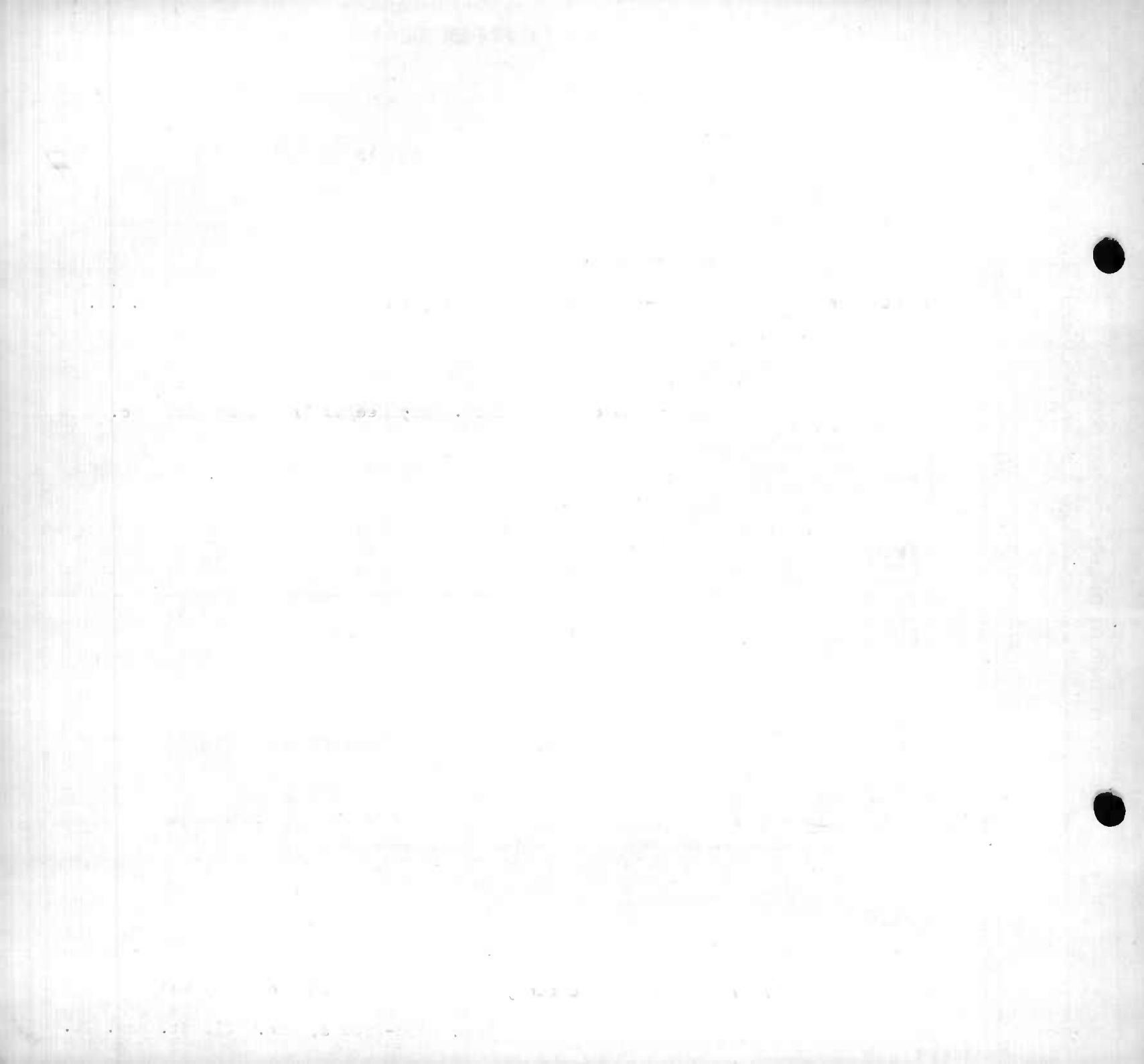
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5167</u>	
BIRTH NO. <u>67 5167</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>67-10050</u>					
1. NAME OF DECEASED (Type or Print) <u>Shirley Dell Smith</u>		2. DATE AND HOUR OF DEATH <u>May 27, 1967</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 South Baltimore General Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>6 N. Irving Place</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <u>6-05</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>May 27, 1967</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no ne</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Elmer C. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Essie M. Lochlear</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Mr. Elmer C. Smith 6 N. Irving Place</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Hydrocephalus</u>		CAUSE OF DEATH (A) DUE TO <u>Spina bifida</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-27-1967</u> to <u>5-27-1967</u> , that (I) (we) last saw the deceased alive on <u>5-27-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cesar L. Tonder</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5-27-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>CESAR L. TONDER</u>		23D. ADDRESS <u>1032 LIGHT ST. BALTIMORE.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/29/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Oxendine Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Lumberton, N.C.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 29 1967</u>		25B. NAME OF REGISTRAR <u>R. L. E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm Cook-Brooks Inc. 1217 St Paul & Preston</u>	

2 mins - received information by phone - 5-1-67 5:27

FUNERAL DIRECTOR: IMPORTANT

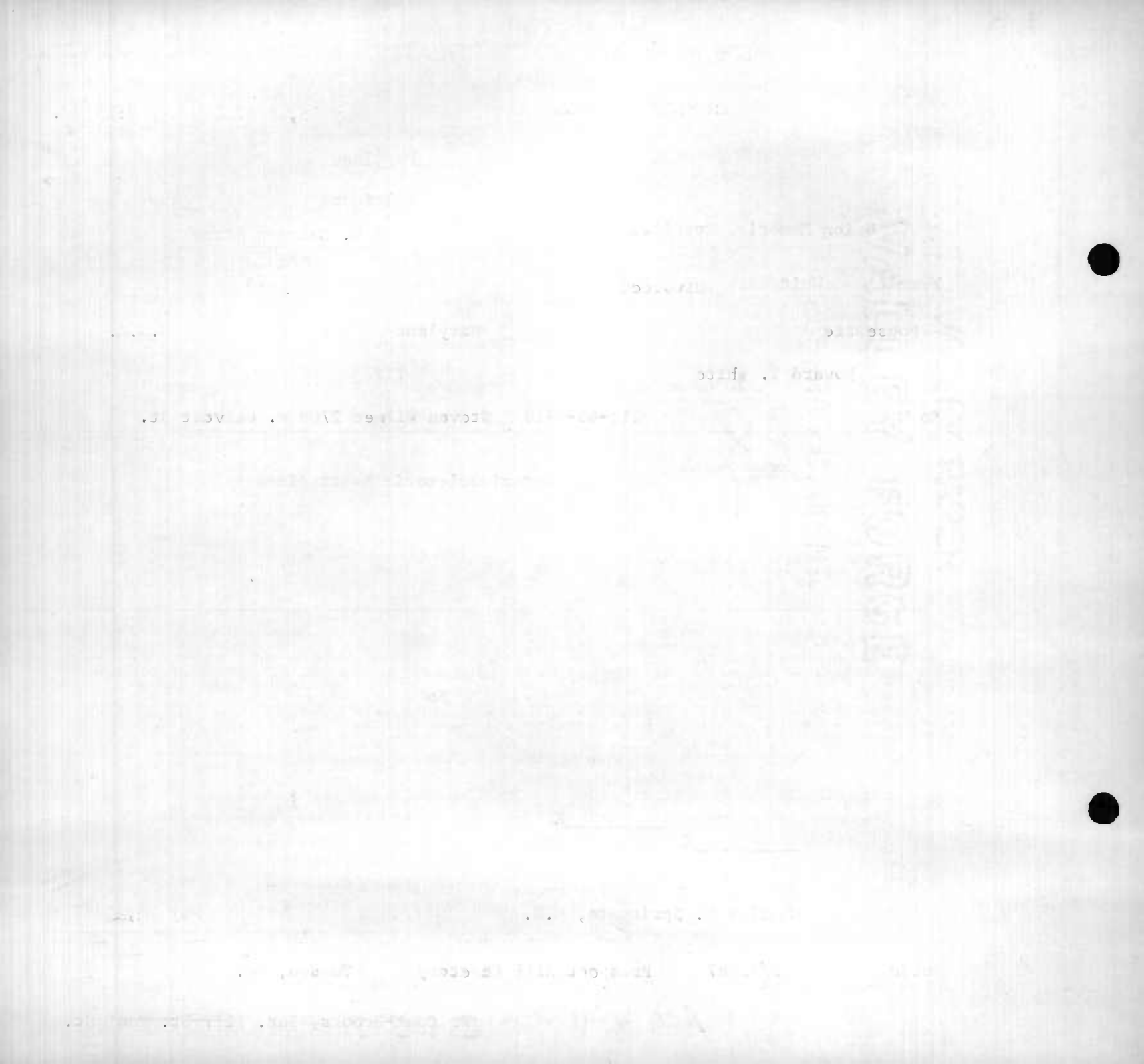
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5168	
BIRTH NO. 67 5168				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BABY BOY MEKINS			2. DATE AND HOUR OF DEATH 5/24/67 3pm M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Baltimore		
FULL NAME OF HDSPITAL DR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND 46			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-17		
D. STREET ADDRESS (If rural, give location) 2711 Spaulding Ave 21215					
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single-Infant	8. DATE OF BIRTH 5/24/67	9. AGE (In years last birthday) 3	10. Under 24 Hrs. Min. 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant-None		10B. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Mekins			14. MOTHER'S MAIDEN NAME Mary Carter		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Mrs. Mary Mekins 2711 Spaulding Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Distress of the Newborn Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PREMATURITY			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 20 min.					
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/24/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 24 19 67 to May 24 19 67 and that (I) (we) last saw the deceased alive on May 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Merama			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/24/67
23C. PHYSICIAN'S NAME (Type) J. Merama			23D. ADDRESS M.D. LUTHERAN HOSP. OF Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/27/67	24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Wm. Cook-Brooks		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St.	



1
T-400

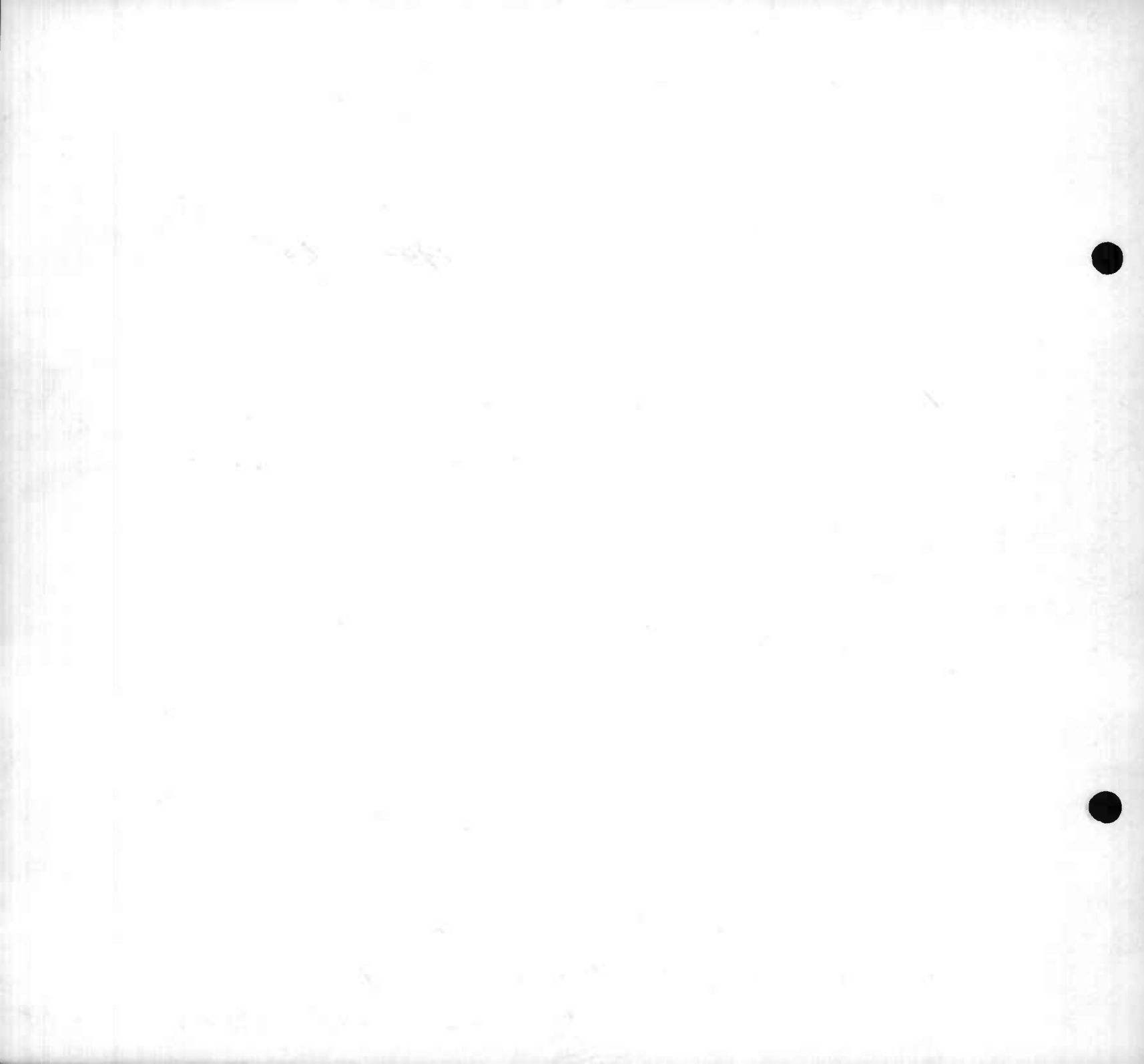
BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5169		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5169	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
CAROLINE TULL		May 25, 1967 9:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
44 Union Memorial Hospital		Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore 12-03	
		D. STREET ADDRESS (If rural, give location)	
		2708 N. Calvert Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Divorced	Nov. 24, 1883
9. AGE (In years last birthday)		10. DATE OF BIRTH	
83 76		Nov. 24, 1883	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Housewife			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland VIRGINIA		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Howard T. White		???	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		216-46-0910	
17. INFORMANT		ADDRESS	
Steven Wilmer		2708 N. Calvert St.	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
Arteriosclerotic heart disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Springate, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED		May 26, 1967	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	
Burial		5/31/67	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Prospect Hill Cemetery		Towson, Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
MAY 29 1967		Wm/Cook-Brooks, Inc. 1217 St. Paul St.	
24C. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

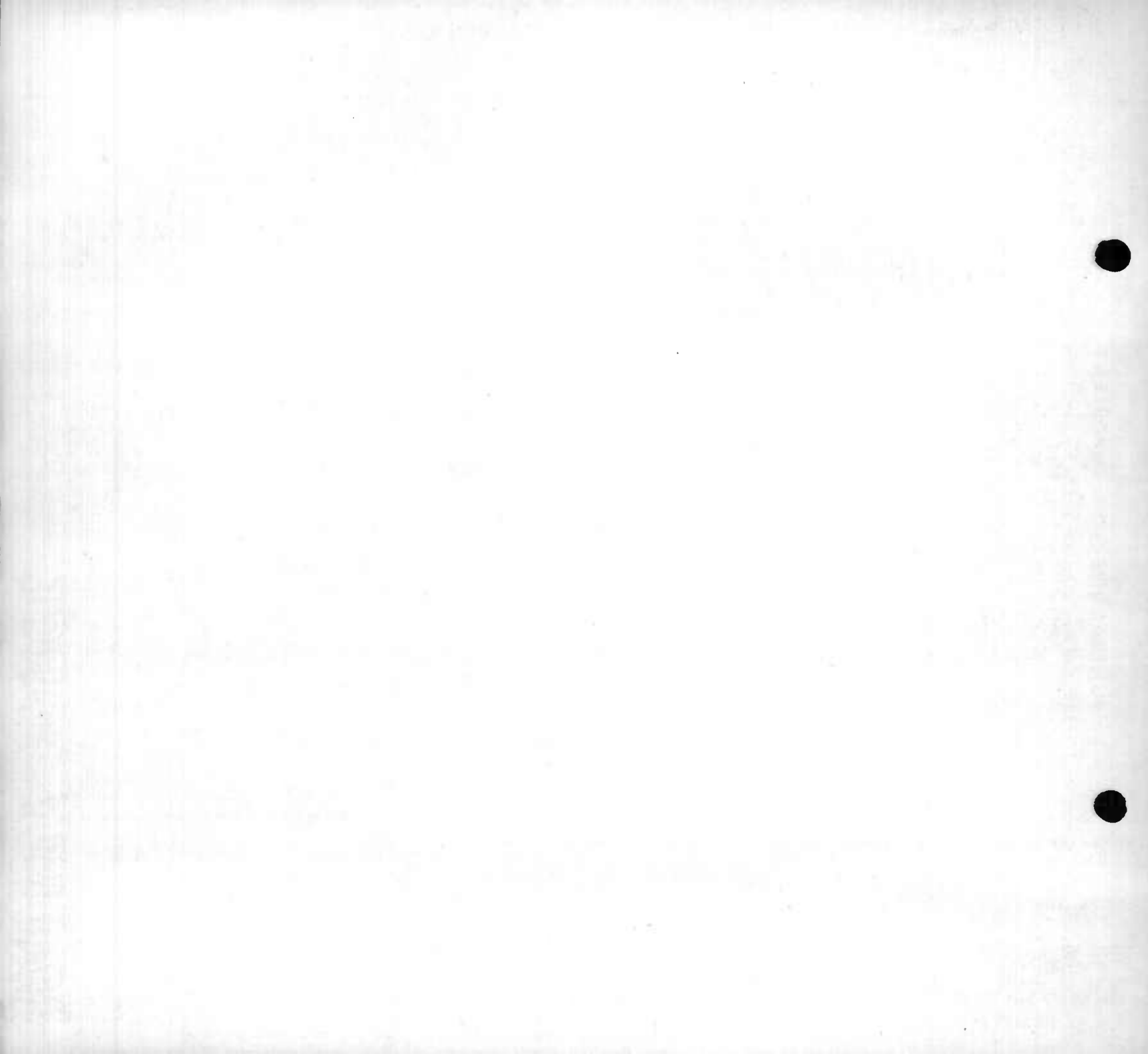
Baltimore City Health Department				Registered No. 67 5170	
BIRTH NO. 67 5170		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MACON, WHITE</u>		2. DATE AND HOUR OF DEATH <u>5/27/67</u> <u>9:30</u> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE <u>MARYLAND</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>36 FRANKLIN SQUARE Hosp.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		D. STREET ADDRESS (If rural, give location) <u>1039 W. FAYETTE ST.</u>	
5. SEX <u>M</u>	6. RACE <u>N N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SEPARATED</u>	8. DATE OF BIRTH <u>4/19/02</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>EDWARD WHITE</u>		14. MOTHER'S MAIDEN NAME <u>MARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2120344283</u>		17. INFORMANT <u>LILLY W. LIE</u> ADDRESS <u>1039 W FAYETTE</u>	
18. <u>443X1-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <u>Acute pulmonary edema</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Hypertensive cardiovascular dis</u>			
		(C) <u>ASCUD w/ HEART BLOCK</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>DIABETES</u>		<u>✓ HYPERTENSION</u>	
19A. DATE OF OPERATION <u>21-</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>also</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/27</u> <u>9:45 AM</u> 19 <u>67</u> to <u>9:30 PM</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5/27/67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Kravitz</u>				23B. DATE SIGNED <u>5/27/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. KRAVITZ</u>				23D. ADDRESS <u>FRANKLIN SQUARE Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (specify) <u>Burned</u>		24B. DATE <u>5/31/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Wt Auburn</u>	
24D. LOCATION (City, town, or county) <u>BALTO MD</u>		24E. FUNERAL DIRECTOR <u>John R. Kravitz</u>		24F. ADDRESS <u>38 N G. L. Moore St</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 29 1967</u>		25B. NAME OF REGISTRAR <u>R. J. Kravitz</u>		25C. FUNERAL DIRECTOR <u>John R. Kravitz</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

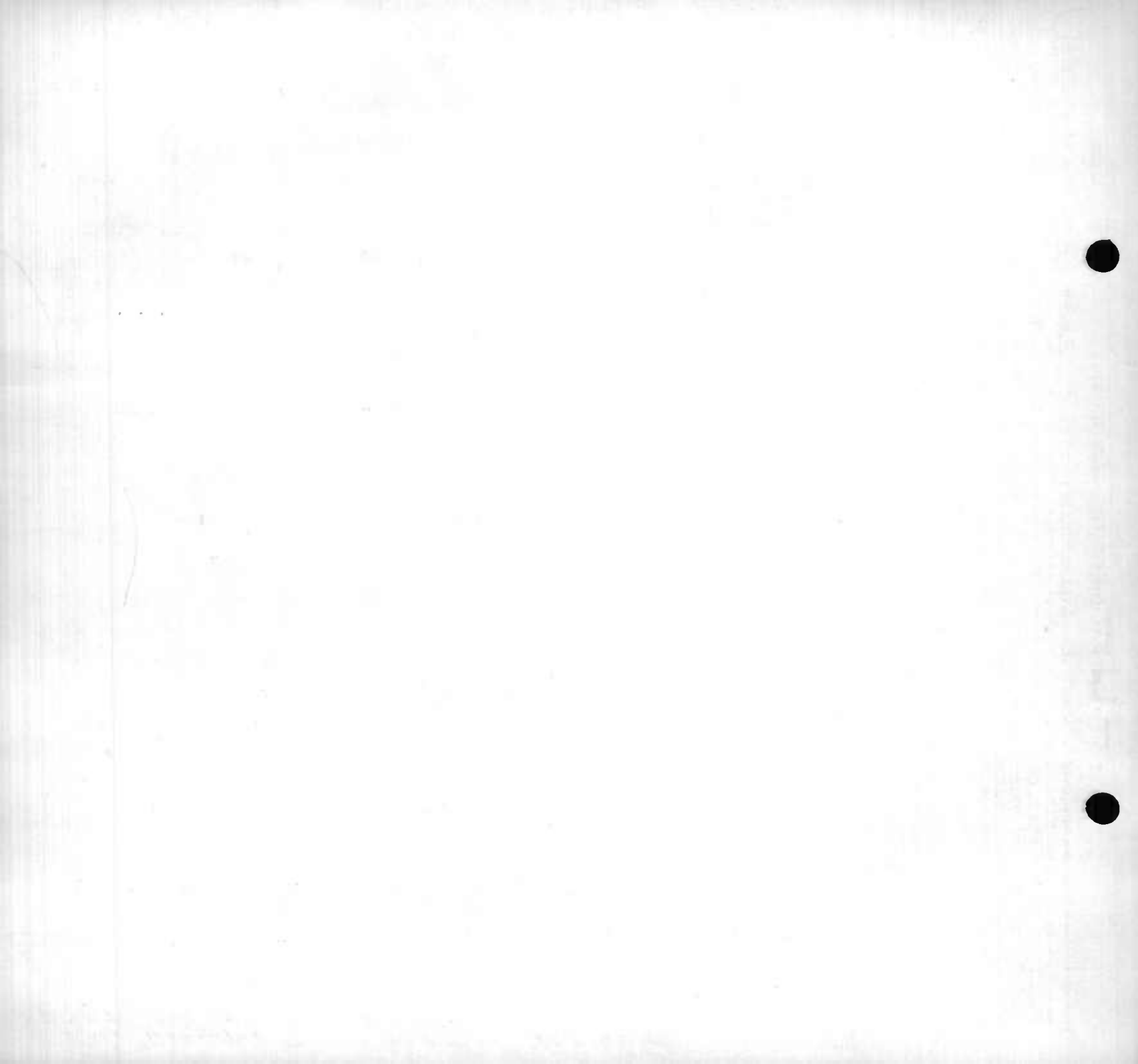
BALTIMORE CITY HEALTH DEPARTMENT										Registered No.	
67 5171										67 5171	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 5171</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) CURTIS L. MILLER</p> </div> <div> <p>2. DATE AND HOUR OF DEATH May 24, 1967 9:00 P. M.</p> </div> </div>											
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>46 Lutheran Hospital</p>						<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 2218 Preston Street</p>					
<p>5. SEX Male</p>		<p>6. RACE Colored</p>		<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married</p>		<p>8. DATE OF BIRTH Dec. 29, 1915</p>		<p>9. AGE (In years last birthday) 57</p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p>				<p>11. BIRTHPLACE (State or foreign country) Perry, Florida</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME John S. Miller</p>						<p>14. MOTHER'S MAIDEN NAME Florence Brown</p>					
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service</p>				<p>16. SOCIAL SECURITY NO. 259-10-3960</p>		<p>17. INFORMANT Rolan J. Miller</p>				<p>ADDRESS 2218 Preston St.</p>	
<p>18. 241X I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) Acute Myocardial Infarction</p> <p>(B) Chronic Bronchial Asthma</p> <p>(C)</p> <p>CAUSE OF DEATH</p> <p>INTERVAL BETWEEN ONSET AND DEATH 2 wks</p>											
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>											
<p>19A. DATE OF OPERATION</p>				<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>				<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>				<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>				<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>				<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from 5-1-67 19 to 5-24 1967, that (I) (we) last saw the deceased alive on 5-24-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>											
<p>23A. SIGNATURE G. Franklin Phillips</p>								<p>M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>		<p>23B. DATE SIGNED 5/26/67</p>	
<p>23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips</p>								<p>23D. ADDRESS M.D. 558 McMillan St Baltimore, Md.</p>			
<p>24A. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE May 27, 1967</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery</p>				<p>24D. LOCATION (City, town, or county) (State) Westport (Baltimore) Md.</p>			
<p>25A. DATE REC'D BY HEALTH DEPT.</p>				<p>25B. NAME OF REGISTRAR Robert E. Jackson</p>				<p>25C. FUNERAL DIRECTOR Joseph L. Kueh</p>			
								<p>ADDRESS 2322 W. North Ave. Baltimore, Md.</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

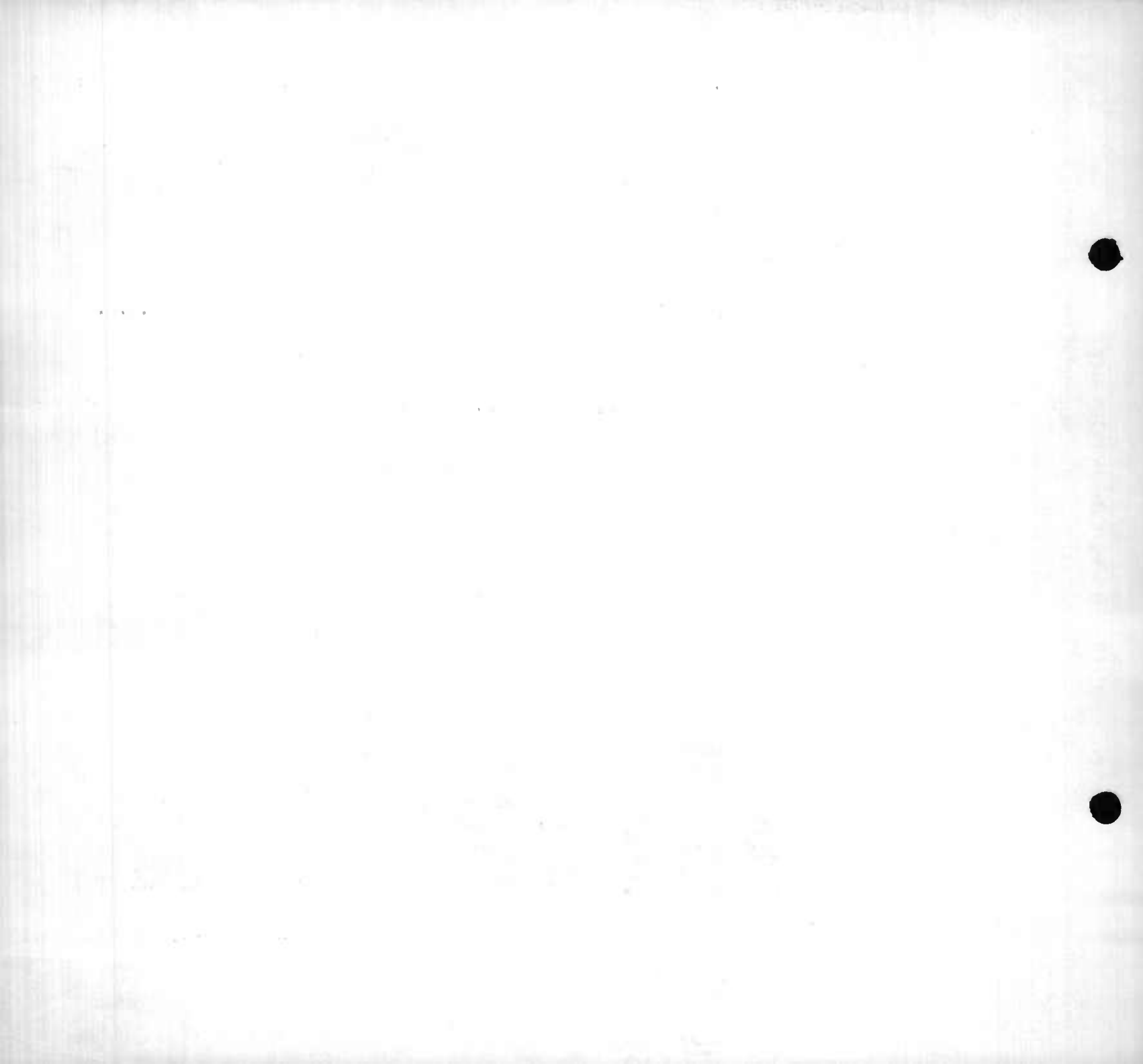
BIRTH NO. 67 5172				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5172	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Oliver Dorsey				2. DATE AND HOUR OF DEATH May 26, 1967 2:30 a. m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 17-02 D. STREET ADDRESS (If rural, give location) 586 Oxford Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH July 21, 1913	9. AGE (In years lost birthday) 53	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY Odd jobs		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME William Franklin Dorsey			14. MOTHER'S MAIDEN NAME Francis Hickens				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph Royal-friend same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 493X1 Pneumonia Dehydration				INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION				20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 24, 19 67 to May 26, 19 67 , that (I) (we) last saw the deceased alive on May 26, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ghahramani Per Amin					23B. DATE SIGNED May 26, 1967		
23C. PHYSICIAN'S NAME (Type) Ghahramani PER/AMINI					23D. ADDRESS 1514 Division Street-Baltimore, Maryland 21217		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 31, 1967	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Wheatport (Baltimore) Md.		
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Joseph L. Hines 2222 W. North Ave. Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

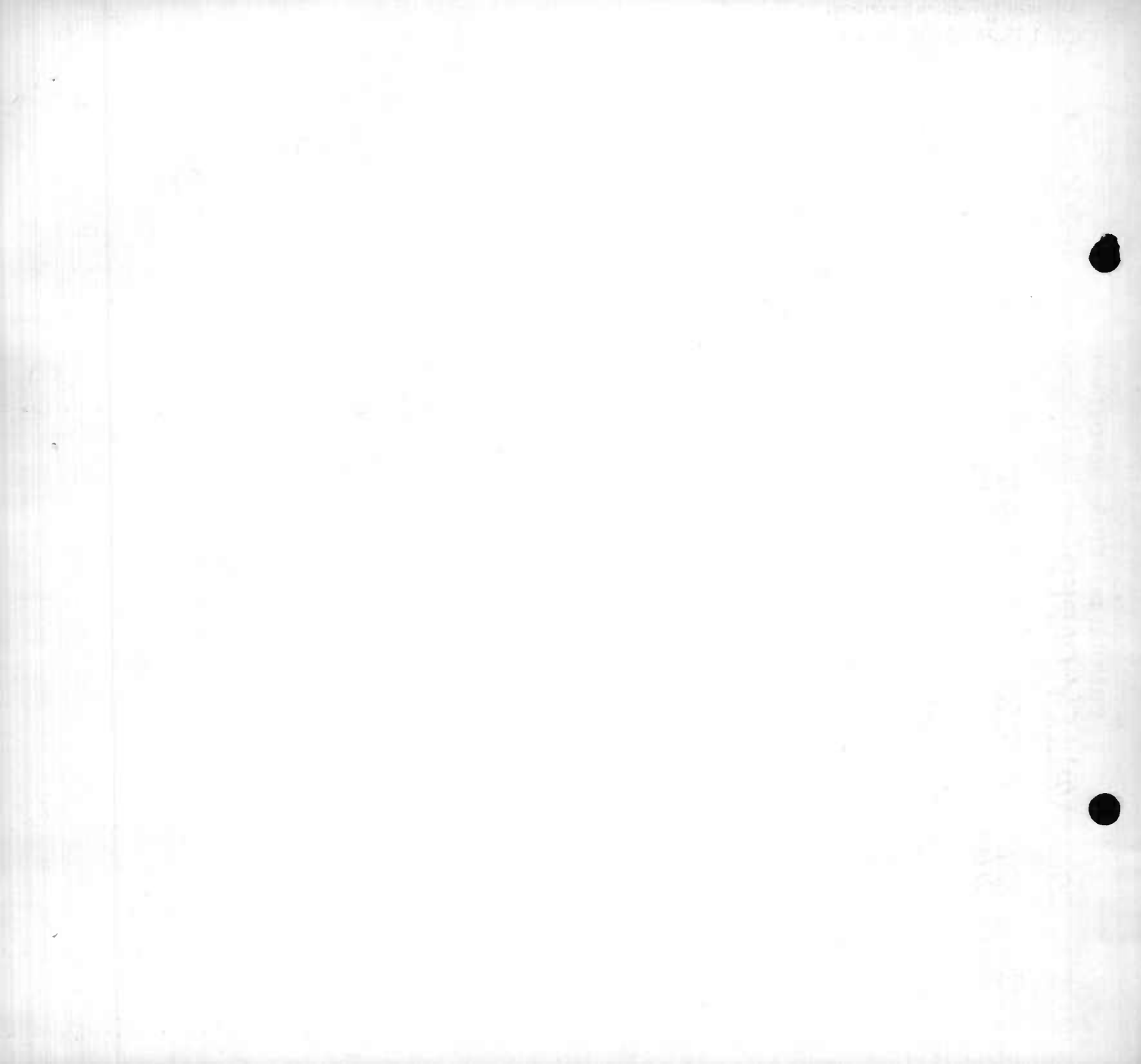
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5173	
BIRTH NO. 67 5173		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Samuel R. Stewart		2. DATE AND HOUR OF DEATH May 21, 1967 4:15 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital (If not in hospital or institution, give street address or location) 1514 Division Street Baltimore, Maryland 21217		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write rural and give township) 27-12 D. STREET ADDRESS (If rural, give location) 424 Hutchins Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 22, 1907	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Club manager		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-094468		17. INFORMANT Lloyal Randolph ADDRESS 3400 Woodbrook Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I Carcinoma of the liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of the liver DUE TO (B) DUE TO (C) 		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 27, 1967 to May 21, 1967 , that (I) (we) last saw the deceased alive on May 21, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ata Amini		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 22, 1967	
23C. PHYSICIAN'S NAME (Type) Ata Amini		23D. ADDRESS M.D. 1514 Division Street-Baltimore, Maryland 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/25/67	24C. NAME of CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR William J. Shultz ADDRESS 1727 M. Names	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5174	
BIRTH NO. 67 5174		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mabel O. Wilson			2. DATE AND HOUR OF DEATH 5/23/67 7 (A.M.)		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) #2 SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-10 D. STREET ADDRESS (If rural, give location) 3803 SEUDIA AVE #15		
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Wid.	8. DATE OF BIRTH 3/22/89	9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Davis			14. MOTHER'S MAIDEN NAME Ella Holmes		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Phyllis Barnum 3803 Sequoia Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 2043 I CAUSE OF DEATH ACUTE LEUKEMIA INTERVAL BETWEEN ONSET AND DEATH 1 month			19. DATE OF OPERATION 5/19/67		
19A. DATE OF OPERATION 5/19/67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Approx.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5/19/67 to 5/23/67, that (I) (we) last saw the deceased alive on 5/23/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eduardo Hidalgo			23B. DATE SIGNED 5/2/67		
23C. PHYSICIAN'S NAME (Type) EDUARDO HIDALGO			23D. ADDRESS Sinai Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/27/67		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Ph. Baltimore Md.	
24D. LOCATION (City, town, or county) Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR Arlington S. Phillips 1737 N. Mount St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5175	
BIRTH NO. 67 5175				CERTIFICATE OF DEATH	
M.E. CASE NO.				Registered No. 67 5175	
1. NAME OF DECEASED (Type or Print) BARNES, WILLIAM MAURICE				2. DATE AND HOUR OF DEATH 5/25/67 11:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 27 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 933 SOUTH KENWOOD AVENUE	
5. SEX MALE	6. RACE CAUCASION	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 12/10/95	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR			10B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME JOHN W. BARNES		
14. MOTHER'S MAIDEN NAME JULIA LONG			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6/1/17 TO 9/30/21		
16. SOCIAL SECURITY NO. 219-07-2215			17. INFORMANT ADDRESS VETERANS ADMINISTRATION HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218		
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEMOPTYSIS, 2° PULMONARY DIATHESIS BILATERAL, MASSIVE II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PULMONARY TBC, OLD & QUESTIONABLY ACTIVE, APICES III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 25 19 67 to MAY 25 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 25 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.			
23A. SIGNATURE <i>Margaret C. Dennis</i>				23B. DATE SIGNED 5/28/67	
23C. PHYSICIAN'S NAME (Type) M.D.				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) 5/31/67 Burial		24B. DATE 5/31/67		24C. NAME OF CEMETERY OR CREMATORY London Nat'l Cem	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967			
25B. NAME OF REGISTRAR Joe E. Isidore		25C. FUNERAL DIRECTOR Joseph Zannino		25D. ADDRESS 2635 S. Conkling	

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

11:11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5176		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5176	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Anita Ruta		
2. DATE AND HOUR OF DEATH May 21, 1967 10:45 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 00 129 S. Eaton Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-08		
5. SEX M F.			6. RACE White		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH 4/29/1897		
9. AGE (In years lost birthday) 70			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		
11. BIRTHPLACE (State or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael Mancini			14. MOTHER'S MAIDEN NAME Josephine Parete		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. 213-07-1947-B		
17. INFORMANT Mrs. Anne Santoni			ADDRESS		
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) P.V. A. ARTERIOSCLEROTIC C.V. DISEASE PERIPNEUMONIA (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hrs 5 yrs 6 mos					
19. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from AUG. 10 1965 to MAY 21 1967 , that (I) (we) last saw the deceased alive on MAY 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benjamin Hochstein			23B. DATE SIGNED 5/23/67		
23C. PHYSICIAN'S NAME (Type) DR. B. HILFSTEIN			23D. ADDRESS 121 S. HIGHLAND AVE		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/24/67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Joseph N. Zannino	
				ADDRESS 263 S. Conling	

Reg. Birth Cert. from Commune Di Casalvecchio Di Puglia— born April 1897

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5177	
BIRTH NO. 67 5177		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>George F. Meals</u>		2. DATE AND HOUR OF DEATH <u>MAY 26, 1967</u> <u>4:15 AM.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>31 Balto. City Hospitals</u> <u>Balto. Md.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Balto. Co.</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>413 Vogts Lane</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1/6/14</u>	9. AGE (In years last birthday) <u>53</u>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Med. Arts Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>Grove City, Pa.</u>	
13. FATHER'S NAME <u>Raymond E. Meals</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Schwan K</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-18-9194</u>		17. INFORMANT ADDRESS	
18. <u>420.01</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <u>CARDIAC FAILURE</u> DUE TO <u>ARTERIO-SCLEROTIC</u>		<u>6 HOURS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>HEART DISEASE</u> DUE TO		<u>10 YEARS</u>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED Wife At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 26, 1957</u> to <u>MAY 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 22, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Joseph M. Keli</u> M.D.				23B. DATE SIGNED <u>5/26/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH M. KELI</u> M.D.				23D. ADDRESS <u>108 S. TAYLOR AVE</u> <u>ESSEX, MD. 21221</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/29/67</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Dakota Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 29 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Joseph N. Zammuto 763 S. Conkling St.</u>	

Handwritten text at the top of the page, possibly a header or title.

Handwritten text in the upper left quadrant.

Handwritten text in the upper right quadrant.

Handwritten text in the middle right quadrant.

Handwritten text in the middle section, possibly a list or series of notes.

Handwritten text in the middle right section.

Handwritten text in the lower left quadrant.

Handwritten text in the lower middle section.

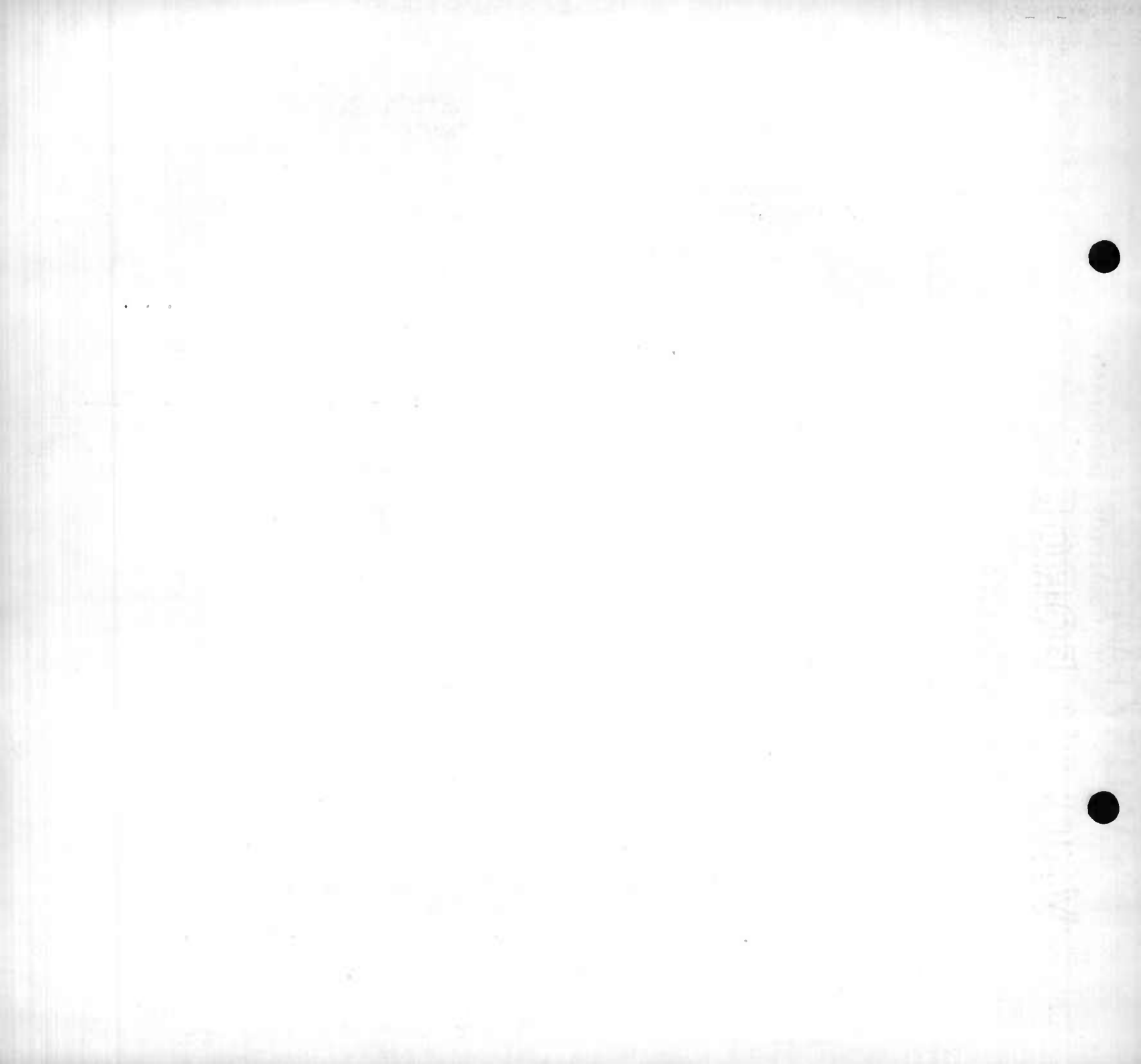
Handwritten text in the lower right quadrant.

Handwritten text at the bottom of the page.

Handwritten text at the very bottom of the page.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5178	
BIRTH NO. 67 5178		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		ANNIE ELIZABETH GROSS		5-25-67 5 ³⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
31 Baltimore City Hospitals		Maryland			
4940 Eastern Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Baltimore, Maryland 21224		Baltimore 23-01			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED	
Female		Negro		WIDOWED, DIVORCED (specify)	
				Single	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
1890		77		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John F. Gross		Sidney Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Records: BCN-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Chronic Renal Failure		> 1 yr	
ANTECEDENT CAUSES		(B) Atherosclerotic Cardiovascular Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/4 19 07 to 5/25 19 07, that (I) (we) lost saw the deceased alive on 5/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
James T. Corkins				5/25/07	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
James T. Corkins		M.D. 4940 Eastern Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/29/67		Mt Auburn Ct	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 29 1967		Robert E. Corkins		108 W. Mount Vernon St. Address	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department CERTIFICATE OF DEATH				Registered No. 67 5179	
BIRTH NO. 67 5179		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILSON ALICE M	
2. DATE AND HOUR OF DEATH 5-27-67 11:35 am		3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION DOA @ ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) 6-6-67			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE		5. SEX F 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		8. DATE OF BIRTH 1896 9. AGE (In years lost birthday) 71			
D. STREET ADDRESS (If rural, give location) 1003 Rock Hill Ave.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			
11. BIRTHPLACE (State or foreign country) BALTIMORE MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JERIMIAH McGRAW		14. MOTHER'S MAIDEN NAME Alice McSherry			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MARY CESKY - 6818 GARRET RD.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemo, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) DUE TO Coronary Occlusion (B) DUE TO Hypertensive Cardio-Vascular 5 Years (C) Release		INTERVAL BETWEEN ONSET AND DEATH Sudden	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/22 19 52 to 57 27 19 67 , that (I) (we) last saw the deceased alive on 5/22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eliot W. Johnson				23B. DATE SIGNED 5/29/67	
23C. PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON				23D. ADDRESS 3432 Frederick Ave Baltimore Md 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/31/67		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL	
24D. LOCATION (City, town, or county) BALTIMORE		(State) MD.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Foley - Cavanagh	
				ADDRESS 6601 Frederick	

MAY 29 1967

V.S. 153

6-6-67

M.H.

S-530

67 5180

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 5180

BIRTH NO.

M.E. CASE NO. 67-5181

1. NAME OF DECEASED
(Type or Print)Duane
DAVID DECKY SMITH

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

11:20 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5921 Plainfield Avenue 21206

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

3/18/67

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

11 weeks

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles David Smith

14. MOTHER'S MAIDEN NAME

Carol Heath

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

Mr. David D. Smith

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Interstitial pneumonitis - (SDII)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-28-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/31/67

23C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Pk.

23D. LOCATION

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 29 1967

Leonard J. Ruck Inc. Balto. Md.

WILL BY FINGER

27440 C. 11/1/10

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1910

1
w-543

67 5181

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5181

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BERNARD C. WIENHOLD

2. DATE AND HOUR PRONOUNCED DEAD

May 25, 1967 2:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Dorchester Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Cambridge

D. STREET ADDRESS (If rural, give location)

720 Glasgow Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Sept. 12, 1939.

9. AGE (in years last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Wire Cloth Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Francis B. Wienhold

14. MOTHER'S MAIDEN NAME

Doris F. Chivaler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unk.

16. SOCIAL SECURITY NO.

216-36-6980

17. INFORMANT

ADDRESS

Mrs. Doris Foerster, Woolford, Md.

18.

330X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Ruptured intracranial saccular aneurysm

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 26, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

5/29/67.

23C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Cem.

23D. LOCATION (City, town, or county) (State)

Elkridge, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 29 1967

24B. NAME OF REGISTRAR

Robert E. Fairley, Jr.

24C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

1
D-550

67 5182

BALTIMORE CITY HEALTH DEPARTMENT

67 5182

BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
JOHN DOMIN			5-27-67 5:45 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
33 JOHNS HOPKINS HOSPITAL			Maryland		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			4010 Ridgcroft Road 21206		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	White	single	3/6/1917	50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Roofer				Pennsylvania	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Larry Domin			unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		181-01-5822		Balto. Md. Mrs. David Stolz 4010 Ridgcroft Rd.	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Multiple traumatic injuries DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Roof of Factory		Atenna Shirt Company - 1000 Race Road - Baltimore Co - Pulaski Hghwy	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour) (Min.) 5 27 '67 4:30 PM		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		Was tarring roof of building-stepped backward through skylight	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		5-28-67	
RUSSELL S. FISHER, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		5/31/67		Gardens of Faith Cem.	
				Balto. Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR	
MAY 29 1967		Robert E. Fisher, Jr.		Leonard J. Ruck Inc. Balto., Md.	

PROFIT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

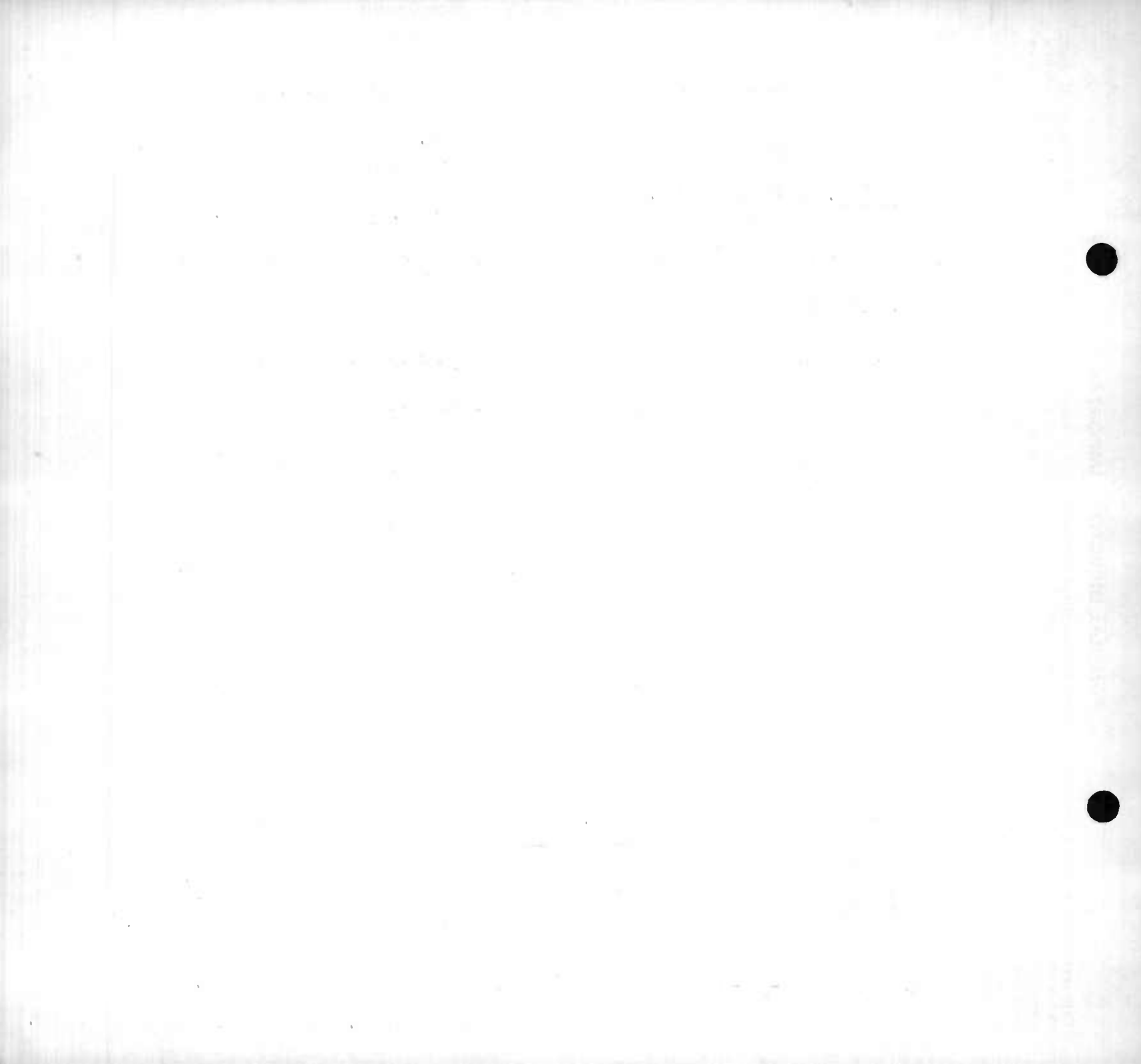
BIRTH NO. 67 5183				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5183	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Edwin Wartfield Gladmon</i>				2. DATE AND HOUR OF DEATH <i>May 28, 1967</i>		8:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>5417 Mayview Ave.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, Md.</i>		<i>26-01</i>	
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) <i>5417 Mayview Ave.</i>			
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>4-7-1898</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Toolmaker</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Western Electric</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John C. Gladmon</i>				14. MOTHER'S MAIDEN NAME <i>Mary Heddrick</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>215010759</i>		17. INFORMANT <i>Esther Gladmon</i>		
			ADDRESS <i>same</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Artery Disease</i>				CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>				(B) DUE TO <i>Chronic cholecystitis</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION <i>5-20-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3-22-67</i> to <i>5-28-67</i> , that (I) (we) last saw the deceased alive on <i>5-23-67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Juri Hinnno</i>						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>JURI HINNO</i>				23D. ADDRESS <i>5002 Frankford Avenue, Baltimore, Maryland</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>5-31-67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens of Faith Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 29 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc</i>		ADDRESS <i>Baltimore, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5184	
CERTIFICATE OF DEATH					
BIRTH NO. 67 5184					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Robert Clark		May 27, 1967		1:55 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE			
(If not in hospital or institution, give street address or location)		Md.			
1438 E. Gittings Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1438 E. Gittings Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
male	white	married	March 1, 1881	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret. Loftsmen		Steel		Scotland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Robert Clark			Elizabeth MacAllister		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		215013087		Christine Clark	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Acute pulmonary edema		sudden immediate	
ANTECEDENT CAUSES		(B) Severe Chronic Myocarditis		5 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Arteriosclerotic C.V. disease			
		(D) Diabetes Mellitus			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
Duodenal ulcer					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from May 21, 1967 to May 27, 1967, that (I) (we) last saw the deceased alive on May 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. V. Harbold				May 29, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H. V. HARBOLD				4706 Harford Road Baltimore Md	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		5-31-67		Oak Lawn Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 29 1967		E. J. Taylor		Leonard J. Ruck, Inc Baltimore, Md.	



1
F-620

BIRTH NO. 67 5185				BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5185					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD									
PIETRO FERRUGGIO				5-26-67 8:00 PM M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY									
00 6116 SEFTON AVENUE				Maryland									
				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)									
				Baltimore									
				D. STREET ADDRESS (If rural, give location)									
				6116 Sefton Avenue 21214									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.			
Male		White		Widowed		Aug. 12, 1893		74 73					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Net. Barber								Italy		U. S. A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME									
Not Known				Not Known									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
Unk.				218-18-6375A		Mrs Victoria Jenkins 7000 Mornington Road							
MEDICAL CERTIFICATION				18. CAUSE OF DEATH								INTERVAL BETWEEN ONSET AND DEATH	
				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
				ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?					
				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED					
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
RUSSELL S. FISHER, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				5-27-67					
23A. BURIAL CREMATION, REMOVAL (Specify)				23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)					
Burial				5-31-67		Holy Redeemer		Baltimore Maryland					
24A. DATE REC'D BY HEALTH DEPT.				24B. NAME OF REGISTRAR				24C. FUNERAL DIRECTOR ADDRESS					
MAY 29 1967				Robert E. Fisher, M.D.				Leonard J. Ruck Inc. 5305 Harford Rd.					

GOVERNMENT

CONTINUED

1-1-75

B-6361

67 5186

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5186

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BERTERMAN, HENRY

J.

2. DATE AND HOUR OF DEATH

5/25/67

10:20 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Maryland General
48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 21206

27-34

D. STREET ADDRESS (If rural, give location)

4111 Granite Ave

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

7/5/98

9. AGE (In years
last birthday)

68

If Under 1 Yr.
Months: Days:If Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

retired

10B. KIND OF BUSINESS OR INDUSTRY

Machinist

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Hermann Berterman

14. MOTHER'S MAIDEN NAME

Martha Nolan

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-07-5315

17. INFORMANT

Mrs. Ruby L. Berterman

ADDRESS

same

18.

42011 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A)

ASCVD

DUE TO

(B)

acute anterior MI

DUE TO

(C)

3 weeks

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/4 1967 to 5/25 1967,
that (I) (we) last saw the deceased alive on 5/25 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ronald Goldner M.D.

Attending
Phys.Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5/25/67

23C. PHYSICIAN'S
NAME (Type)

Ronald Goldner

M.D.

23D. ADDRESS

Md. General Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/29/67.

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 29 1967

25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1930

1930

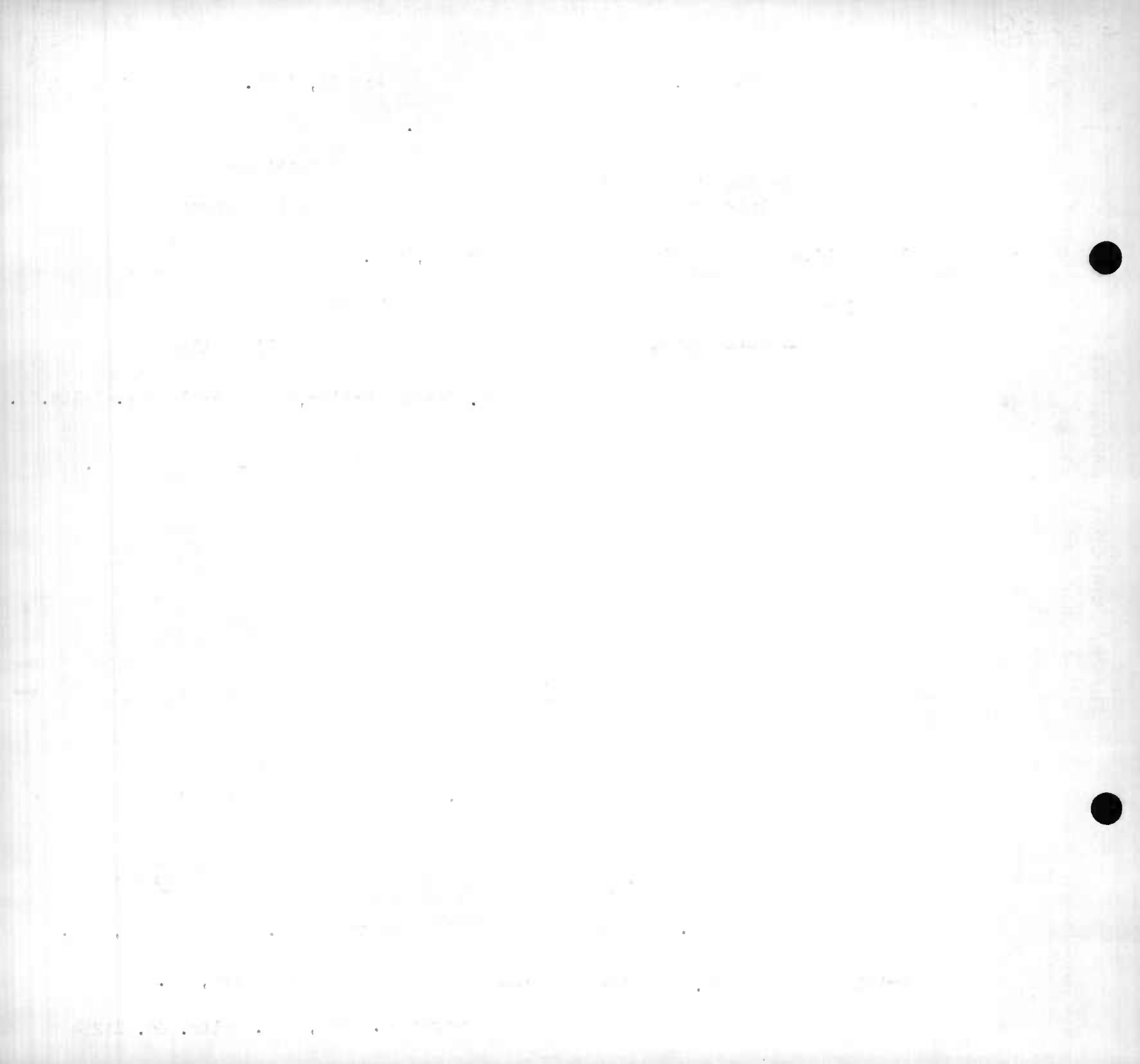
1930

1930

1930

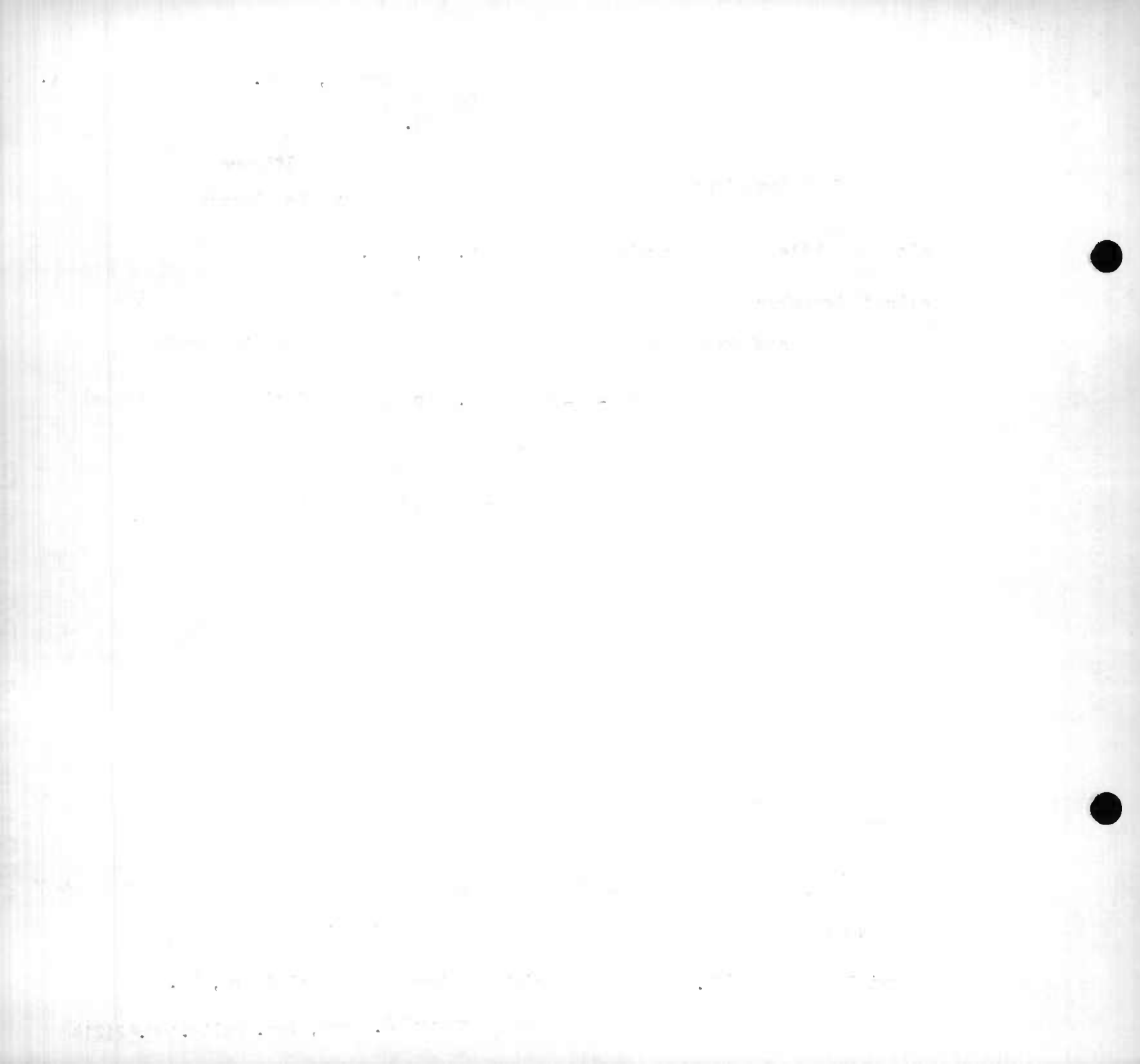
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5187	
BIRTH NO. 67 5187		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CORA D. GENTILE		2. DATE AND HOUR OF DEATH May 25, 1967. 5:20 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines Nursing Home Belair Road		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-09		D. STREET ADDRESS (If rural, give location) 3902 Foster Avenue	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH March 5, 1891.	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick Nolte		14. MOTHER'S MAIDEN NAME Dina Wilke	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Joseph Gentile, 6824 Everall Ave. Balto. Md.	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Arteriosclerotic Cardio-vascular Disease		7 yrs.	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 19 60 to May 25 19 67, that (I) (we) last saw the deceased alive on May 19 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence W. LeDoux M.D.		23B. DATE SIGNED 5/26/67			
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux M.D.		23D. ADDRESS 3023 Eastern Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67		24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Sisk		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5188	
BIRTH NO. 67 5188		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHN CANGELOSI		2. DATE AND HOUR OF DEATH May 26, 1967. 8 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 5930 The Alameda		A. STATE Md. B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-38			
		D. STREET ADDRESS (If rural, give location) 5930 The Alameda			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 28, 1895.	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Shoemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph Cangelosi			14. MOTHER'S MAIDEN NAME Rosario Maggio		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-6565		17. INFORMANT Mrs. Annetta Cangelosi ADDRESS (Same)	
18. 163 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of the Lung (st. hilar mass & infiltration) DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/15 19 67 to 5/26 19 67 , that (I) (we) last saw the deceased alive on 5/23 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert W. Gebhardt M.D.				23B. DATE SIGNED 5/26/1967	
23C. PHYSICIAN'S NAME (Type) ROBERT W. GEBHARDT M.D.				23D. ADDRESS 1211 NORTHERN PKWY. BALTO, MD 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67.		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967		25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5189	
BIRTH NO. 67 5189		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 5/26/67 5:20 PM.	
1. NAME OF DECEASED (Type or Print) Philip Joseph DRAGO (Filippo)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 441 Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21206 26-01 D. STREET ADDRESS (If rural, give location) 5511 Knell Ave.	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	B. DATE OF BIRTH 10-12-00
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brewing Co.		11. BIRTHPLACE (State or foreign country) Italy	9. AGE (In years last birthday) 66
13. FATHER'S NAME Joseph Drago		14. MOTHER'S MAIDEN NAME Rosa Pediti	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-6857	17. INFORMANT ADDRESS Patient chart
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 7 12 hrs	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 5/26 1967 to 5/26 1967 , that (we) last saw the deceased alive on 5/26 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE John R. Vaughn Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 5/26/67
23C. PHYSICIAN'S NAME (Type) JOHN R VAUGHN MD		23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/31/67.	24C. NAME of CEMETERY or CREMATORY Moreland Memorial Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. MAY 29 1967	25B. NAME OF REGISTRAR Robert E. Jenkins	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	

2/20/70
England Baltimore

2211 Knoll Ave.

10-15-00

Italy

Rosa

Robert

Charles H. Thompson

Male 10-15-00

not known

Joseph Darg.

not known

No

2/20

John E. Vlahos

2/20/70

2/20/70

2/20/70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5190	
CERTIFICATE OF DEATH				Registered No. 67 5190	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Hughes, Mrs. Kathleen K.		5/26/67		1 3 ⁴⁰ a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Md. General Hosp. 48		Md.		Baltimore City	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore		2120	
		D. STREET ADDRESS (If rural, give location)			
		500 W. University Pkwy.		1307	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	White	Widow	2/7/49	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		-		Wisc. onsin	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Thomas Kennedy		Mary Shields		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		566-5246628		Shiela Leslie same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		ACUTE LEUKEMIA (STEM CELL TYPE) - 4 mos			
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/13 1967 to 5/26 1967, that (I) (we) lost saw the deceased alive on 5/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ronald Goldner				5/26/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Ronald Goldner		827 Linden			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/29/67		St. Michaels Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Brookfield, Missouri.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 29 1967		E. E. E. E.		Leonard J. Ruck, Inc. Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5191				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5191	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GEORGE HEATERICH				2. DATE AND HOUR OF DEATH 5/27/67 13:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE		(If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY BALTO.	
5. SEX M				6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	
8. DATE OF BIRTH MAY 15-1909				9. AGE (In years last birthday) 58		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST				10B. KIND OF BUSINESS OR INDUSTRY MARTIN CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME George W. Heaterich			
14. MOTHER'S MAIDEN NAME CHRISTINA BUBERT				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 212-01-8070				17. INFORMANT Family			
18. CAUSE OF DEATH 420.11				INTERVAL BETWEEN ONSET AND DEATH 1 day			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/26 19 67 to 5/27 19 67 , that (I) (we) last saw the deceased alive on 5/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Abe Levy				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/27/67	
23C. PHYSICIAN'S NAME (Type) Abe Levy				23D. ADDRESS Sinai Hospital of Balt.			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-31-67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR C. F. Evans		ADDRESS Sm 8802 Hanford Rd	

M W MAY

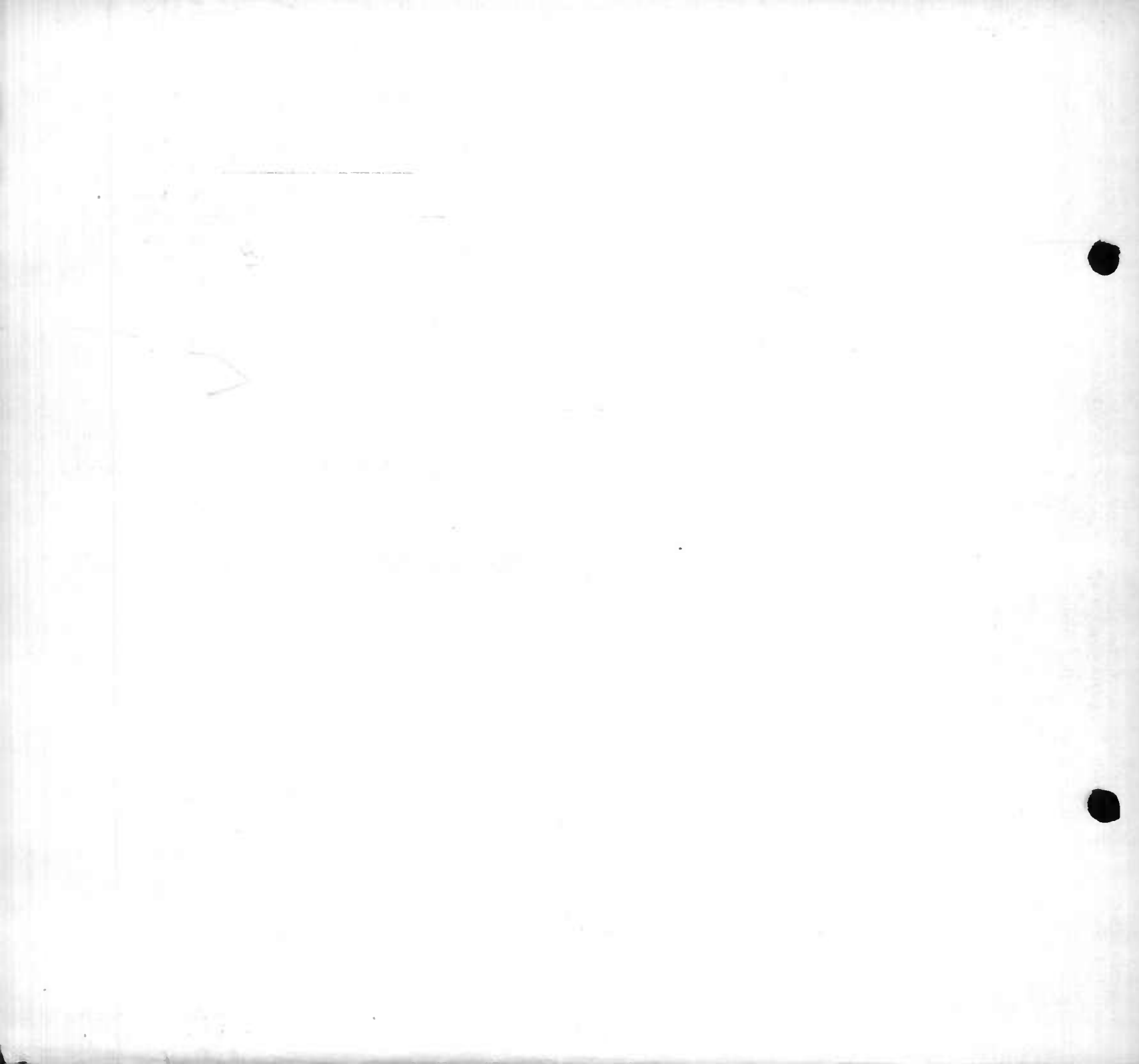
1. of ...
...

... son
...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

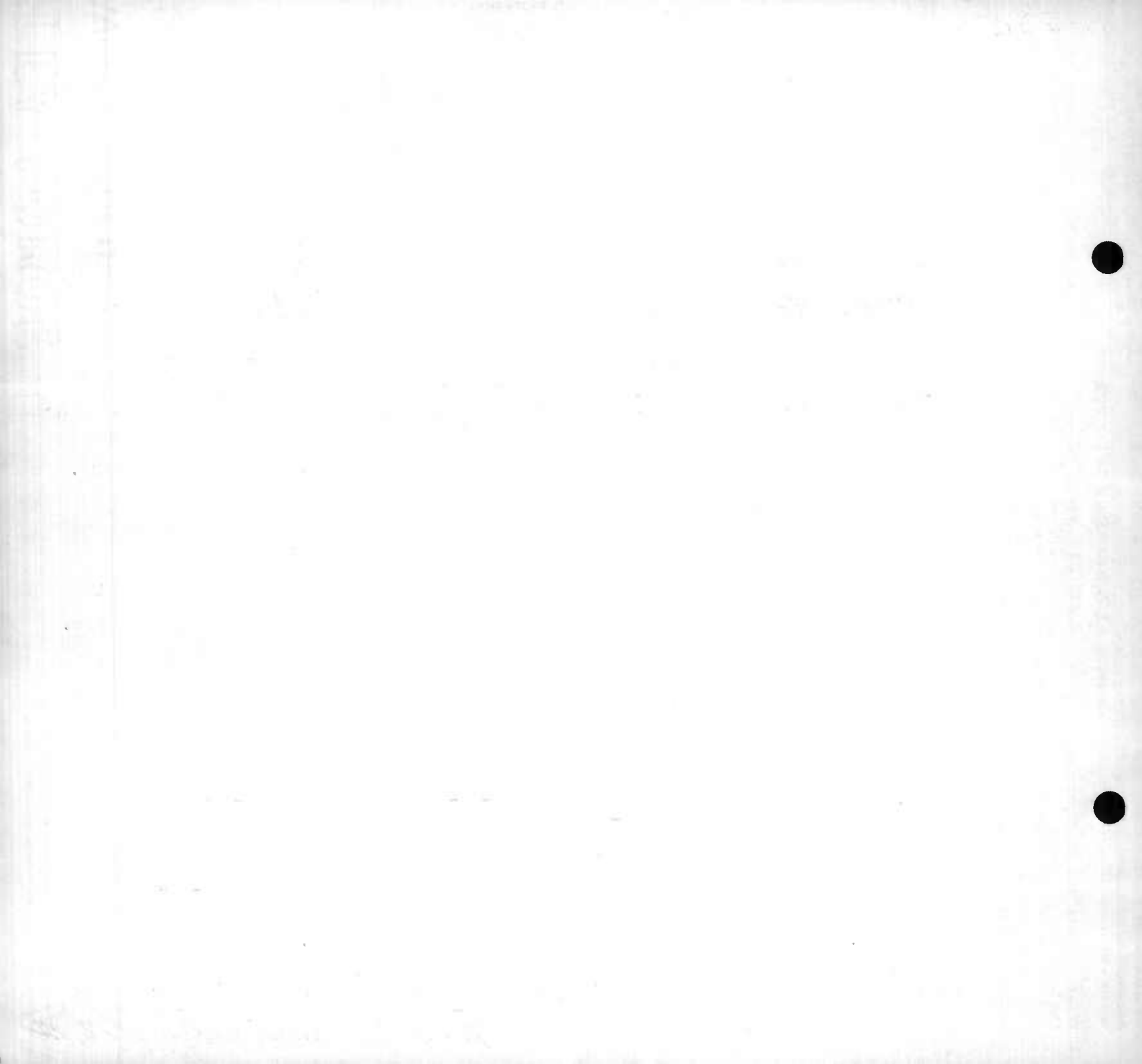
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5192	
BIRTH NO. 67 5192		CERTIFICATE OF DEATH		Registered No. 67 5192	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Rose Mary Monday</i>		2. DATE AND HOUR OF DEATH <i>5/25/67 8:35 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Queen Anne's</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Annapolis</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing Home</i>		D. STREET ADDRESS (If rural, give location) <i>850 West St.</i>		E. CITY OR TOWN (If rural, give location) <i>Annapolis</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>10/15/88</i>	9. AGE (In years last birthday) <i>78</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>never worked</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Charles Henry Beall</i>		14. MOTHER'S MAIDEN NAME <i>Laura Ann (last name unknown)</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>214-54-0807</i>		17. INFORMANT <i>Dorothy Aisquith</i>		ADDRESS <i>Annapolis</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Decubitus ulcer</i> DUE TO (C) <i>Malnutrition and dehydration</i>		INTERVAL BETWEEN ONSET AND DEATH <i>months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/17 1967</i> to <i>5/25 1967</i> that (I) (we) last saw the deceased alive on <i>5/25 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>ALLAN H. MACHT</i>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/25/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT</i>		23D. ADDRESS <i>2 EAST READ ST 21002</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/27/67</i>		24C. NAME of CEMETERY or CREMATORY <i>All Hallows Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Birdsville Anne Arundel Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 31 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Beverly E. Hopping</i>			
HOPPING FUNERAL HOME - Annapolis, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

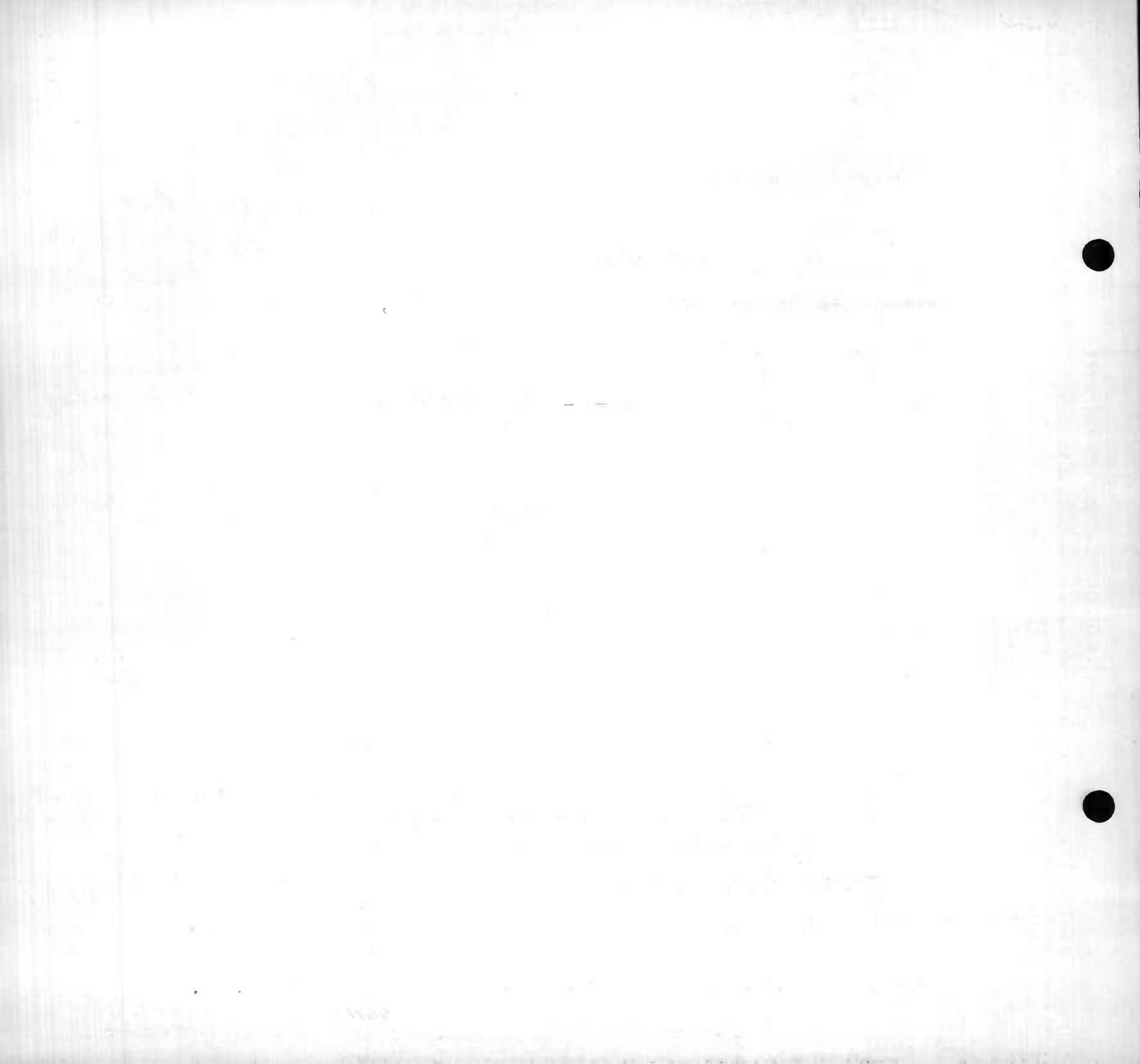
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5193	
BIRTH NO. 67 5193		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Daisy E. Anderson</u>		2. DATE AND HOUR OF DEATH <u>May 23 1967</u> <u>1</u> <u>17</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>20-08</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Bolton Hill Nursing Home</u>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <u>461 Yale Ave</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-20-1896</u>	9. AGE (In years lost birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wilson, N. C.</u>	
13. FATHER'S NAME <u>VERNE H. SOY</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-03-3287</u>		17. INFORMANT <u>M. James V. Anderson</u> ADDRESS <u>Pikesville 8, Md. 939 Elmwood</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>generalized arteriosclerosis</u>		CAUSE OF DEATH (A) DUE TO <u>several yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		diminished vision		several yrs.	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1-17-66</u> to <u>5-23-67</u> that (I) (we) lost <u>saw</u> the deceased alive on <u>5-22-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Ellsworth Cook</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>5-23-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. ELLSWORTH COOK</u>		23D. ADDRESS M.D. <u>2431 Maryland Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 25, 1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Episcopal Park Cemetery, Portsmouth, Virginia</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 31 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville 8, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5194					CERTIFICATE OF DEATH			Registered No. 67 5194	
1. NAME OF DECEASED (Type or Print) <i>Theresa Feret</i>					2. DATE AND HOUR OF DEATH <i>5/26/67 16:30 P M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>H9 North Charles Gen. Hosp</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore City</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 29-16</i> D. STREET ADDRESS (If rural, give location) <i>4636 Park Heights Ave.</i>				
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>12-21-08</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife-Manager</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Drug Store</i>		11. BIRTHPLACE (State or foreign country) <i>Md, Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>		
13. FATHER'S NAME <i>Charles Lusko</i>					14. MOTHER'S MAIDEN NAME <i>Rose Catanese</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>215-10-3054</i>		17. INFORMANT <i>North Charles General Hospital</i>			ADDRESS	
18. <i>153.81</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Pulmonary embolus</i> DUE TO (B) <i>Postop Hemicolectomy for Adenoca - 5ds.</i> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <i>immed.</i>	
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>5-22-67</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CA of colon</i>			20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5-20</i> 19 <i>67</i> to <i>5/26</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5-26</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Marcelina Cruz</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>5/26/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Marcelina Cruz</i> M.D.					23D. ADDRESS <i>North Charles Gen Hosp.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>5/30/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Cathedral Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 31 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>			25C. FUNERAL DIRECTOR <i>4611 Park Heights Ave. Vernon Lemmon</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5195		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5195	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>White, John Aloysius</i>		2. DATE AND HOUR OF DEATH <i>5/25/67 10⁵⁰ AM.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 2712</i>			
		D. STREET ADDRESS (If rural, give location) <i>313 Gittings Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>6-22-88</i>	9. AGE (In years lost birthday) <i>78</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) <i>Life Pres. Mack Truck Co.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Not Known</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Robert White</i>		14. MOTHER'S MAIDEN NAME <i>Johanna Kane</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>XXXXXXX no</i>		16. SOCIAL SECURITY NO. <i>216-01-7860</i>		17. INFORMANT <i>Mrs. Thomas P. Keating Jr. 203 Upnor Rd.</i>	
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <i>Ruptured Left Ventricle</i>		(B) DUE TO <i>Acute Myocardial Infarction 48-72 hrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>Acute Myocardial Infarction 48-72 hrs.</i>		<i>A.B. Penny</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>5-23-1967</i> to <i>5-25-1967</i> , that we (we) last saw the deceased alive on <i>5/25</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John R. Vayhn Jr.</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/25/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. John R. Vayhn Jr.</i>		23D. ADDRESS <i>Union Memorial Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/26/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Dulaney Valley</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. County, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 31 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Falkner</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</i>			

2/22/22
Handwritten notes at the top left.

Handwritten notes in the upper middle section.

Handwritten notes in the middle left section.

~~Handwritten text, possibly crossed out or a header.~~

Handwritten notes in the lower middle section.

Handwritten notes in the lower left section.

Handwritten notes at the bottom left.

Handwritten notes in the upper right section.

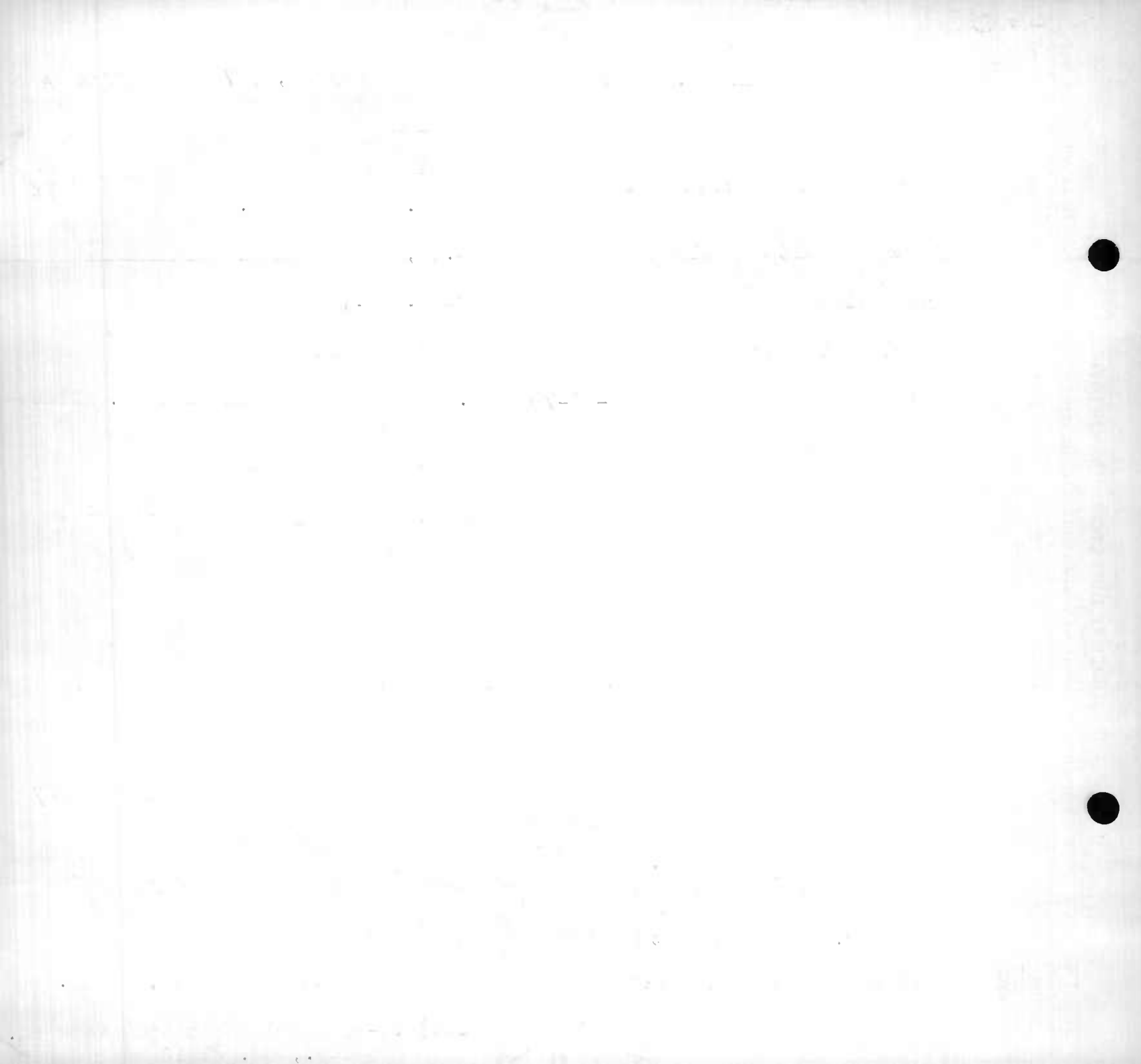
Handwritten notes in the middle right section.

Handwritten notes at the bottom right.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5196	
BIRTH NO. 67 5196		CERTIFICATE OF DEATH		Registered No. 67 5196	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Emelie E. Knorr			2. DATE AND HOUR OF DEATH May 26, 1967 3:50 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Long Green Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-12 D. STREET ADDRESS (If rural, give location) 115 E. Melrose Ave.		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED widowed	8. DATE OF BIRTH Oct. 10, 1884	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Chris Weissner			14. MOTHER'S MAIDEN NAME Suzanne Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-46-7496	17. INFORMANT ADDRESS Mr. Fred Knorr 9 Hillside Rd. #21204		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Cardiac Failure Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from July 10 1960 to May 26 1967 , that (I) (we) last saw the deceased alive on May 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 3:50 A.M.					
23A. SIGNATURE Laurence C. Post			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/26/67
23C. PHYSICIAN'S NAME (Type) Dr. Laurence Post			23D. ADDRESS M.D. 6805 York Road		
24A. BURIAL CREMATION, REMOVAL (Specify) burial	24B. DATE 5/26/67	24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212	



1
L-516

BALTIMORE CITY HEALTH DEPARTMENT					
BIRTH NO. 67 5197			MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5197		
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) JACOB L. LAMBERT			2. DATE AND HOUR PRONOUNCED DEAD May 24, 1967 3:13 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital (DOA)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto. Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 13 St. Michaels Way		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH August 24, 1892	9. AGE (In years last birthday) 74	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York, New York	
13. FATHER'S NAME William Lambert			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I			17. INFORMANT ADDRESS A Mr. Herbert W. Schaefer Same		
16. SOCIAL SECURITY NO. 213-12-0886					
18. CAUSE OF DEATH 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 25, 1967					
23A. BURIAL CREMATION, REMOVAL (Specify) Cremation		23B. DATE 5-26-67		23C. NAME of CEMETERY or CREMATORY Green Mount	
24A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		24B. NAME OF REGISTRAR Robert E. Taylor		24C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 1650 York Road Baltimore, Md.	
23D. LOCATION (City, town, or county) (State) Baltimore, Maryland					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5198	
BIRTH NO. 67 5198		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Frederick Hanssen			2. DATE AND HOUR OF DEATH May 28, 1967 1:30 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesarium 6776 Belair Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-09 D. STREET ADDRESS (If rural, give location) 4531 Northwood Drive		
5. SEX M.	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 9/30/1887	9. AGE (in years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer retired		10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Frederick Hanssen		
14. MOTHER'S MAIDEN NAME Lillian Schipenling			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. unknown			17. INFORMANT Mrs. Mary Maenner 4531 Northwood Drive		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 420.1			CAUSE OF DEATH (A) DUE TO Arteriosclerotic Cardio-Vascular Disease. (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5-28-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-10-67 to 5-28-67 , that (I) (we) last saw the deceased alive on 5-10-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. G. Tilley			23B. DATE SIGNED 5-29-67		
23C. PHYSICIAN'S NAME (Type) L. G. Tilley			23D. ADDRESS M.D. 1713 Taylor Ave Baltimore, Md 21234		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			
25B. NAME OF REGISTRAR L. G. Tilley		25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St			

TO BE APPROVED BY THE MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 67 5199											
CERTIFICATE OF DEATH											
Registered No. 67 5199											
1. NAME OF DECEASED (Type or Print) WILLIAM J. MAZUREK						2. DATE AND HOUR OF DEATH 5-27-67 1:45 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL 34 (If not in hospital or institution, give street address or location)						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1115 STEELTON AVE					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 1-11-16	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) BALTIMORE			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME MARTIN MAZUREK						14. MOTHER'S MAIDEN NAME MARTHA WOLINSKI					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 212-09-9256			17. INFORMANT PATIENT'S CHART			ADDRESS		
18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cancer of the lung						INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from May 17, 1967 to May 27, 1967 , that (I) (we) lost saw the deceased alive on May 27, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE S. W. Wong						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 5-27-67		
23C. PHYSICIAN'S NAME (Type) SOO WONG. HONG						23D. ADDRESS M.D. 4800 Westland Blvd. A. Baltimore, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 5-30-67			24C. NAME of CEMETERY or CREMATORY Sacred Heart of Mary			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			25B. NAME OF REGISTRAR RECEIVED			25C. FUNERAL DIRECTOR Walter Dabrowski			ADDRESS 1005 Dundalk Avenue		

CO. 4000 ft. 10 9 1

WATER MARK
MAY 11 1911
THE DISTRICT
OFFICE
AT
MAY 11 1911
MAY 11 1911

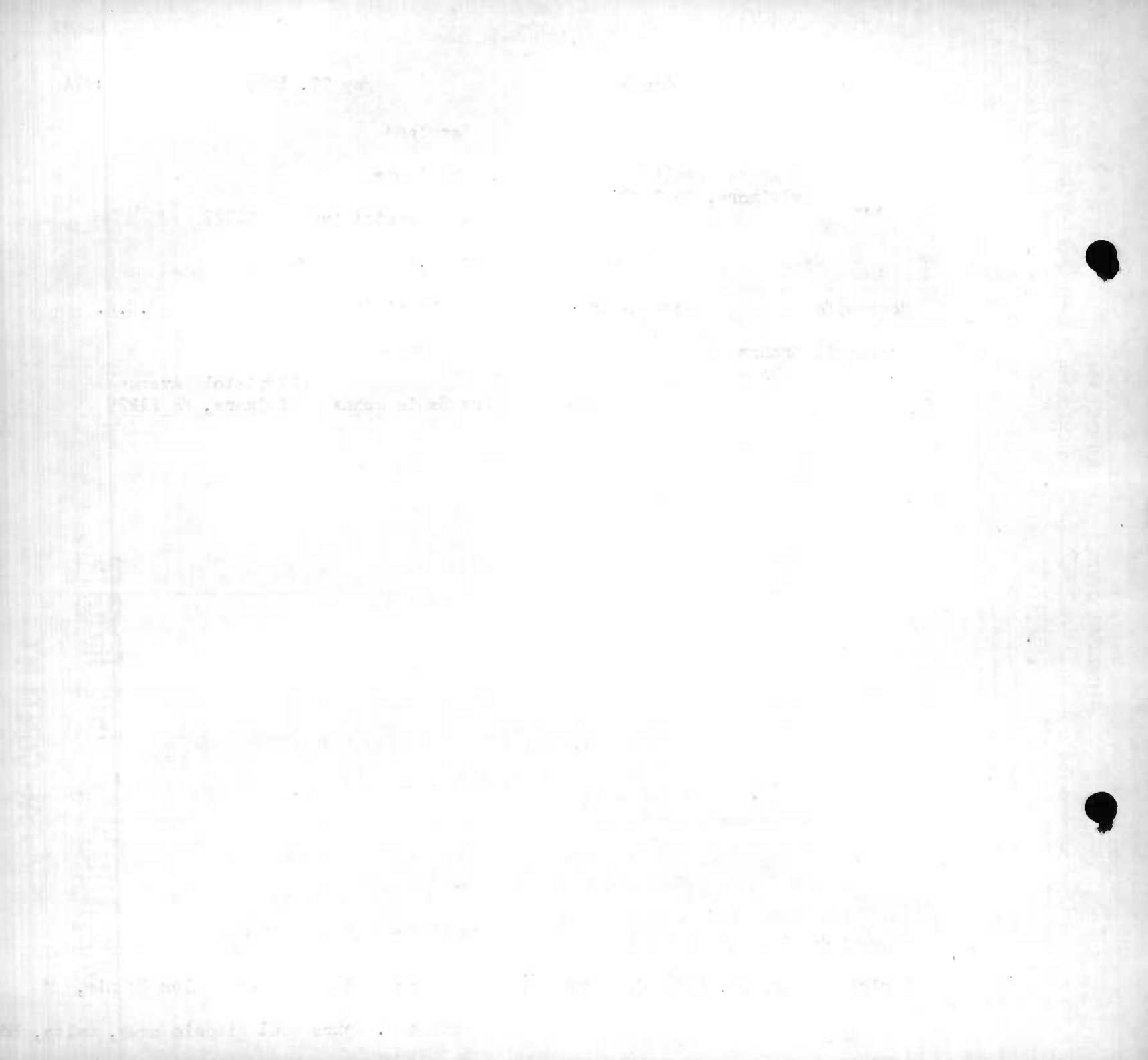
For the purpose of

5-11-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
67 5200					Registered No. 67 5200				
CERTIFICATE OF DEATH									
BIRTH NO. 67 5200					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Mary Adcock					2. DATE AND HOUR OF DEATH May 27, 1967 5:27A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION St Agnes Hospital Baltimore, Md 21229					A. STATE Maryland B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) # 2 Bristol Ave 21225				
5. SEX F	6. RACE Cauc	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Dec 25, 1875	9. AGE (In years last birthday) 91	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home maker		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Marshall Braham					14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Sadie Johns				
					ADDRESS #2 Bristol Avenue Baltimore, Md 21225				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD E									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from MAY 27 1960 to MAY 27 1967 , that (I) (we) lost saw the deceased alive on MAY 27 1967 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Andrew R. Sosnowski					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 5/29/67	
23C. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski					23D. ADDRESS 4016 Ritchie Hwy.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE May 31, 1967		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Ritchie Hwy Glen Burnie, Md		
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR George J. Gonce				
					ADDRESS 4001 Ritchie Hwy, Balto, Md				



H-550
H-555

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5201			
BIRTH NO. 66-12621				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR PRONOUNCED DEAD			
ERIK PAUL HEINMAN (Heineman)				5-28-67 12:25 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
A. STATE				B. COUNTY			
Maryland				Baltimore			
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)				14-01			
D. STREET ADDRESS (If rural, give location)				1514 Bolton Street 21217			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	White	SINGLE	June 18, 1966	11			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
NONE		NONE		Baltimore, Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Paul T. Heineman				Muriel Seelye			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				NONE		Paul T. Heineman, 1514 Bolton St., City	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
Hemorrhagic pulmonary edema and aspiration pneumonitis due to Drowning							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO			
Drowning							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		14-01	
		Home-Bathtub		1514 Bolton Street - Bathroom			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		Mother left baby in tub for a few minutes - found face down in water when she returned	
(Month) (Day) (Year) (Hour) (PM/AM)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					
5 27 '67 7:00 PM							
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		5-28-67	
RUSSELL S. FISHER, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Cremation		5/30/67		Green Mount Cemetery		Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
MAY 31 1967		Robert E. Fisher, M.D.		Stewart & Bowen Co., 108 W. North Av.,			

N990X

Letter from M.E.'s office

6-5-67

M.H.

67 5202
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5202

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DOUGLAS MARK

ALBERTS

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

1:15 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

37 MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

Anne Arundel Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Glen Burnie

D. STREET ADDRESS (If rural, give location)

1612 Jennings Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

5 Oct. 1958

9. AGE (in years
last birthday)

8

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Student

11. BIRTHPLACE (State or foreign country)

Annapolis, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Douglas A. Alberts

14. MOTHER'S MAIDEN NAME

Iris S. DeBusk

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Douglas A. Alberts - Same as # 4

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, lorn, factory, street, office bldg.,
etc.)

Highway

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? Ritchie Highway - 100 ft.

South of Gilford Road

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 26 '67 7:15 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-27-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

May 31, 67

23C. NAME of CEMETERY or CREMATORY

U.S. National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 31 1967

24B. NAME OF REGISTRAR

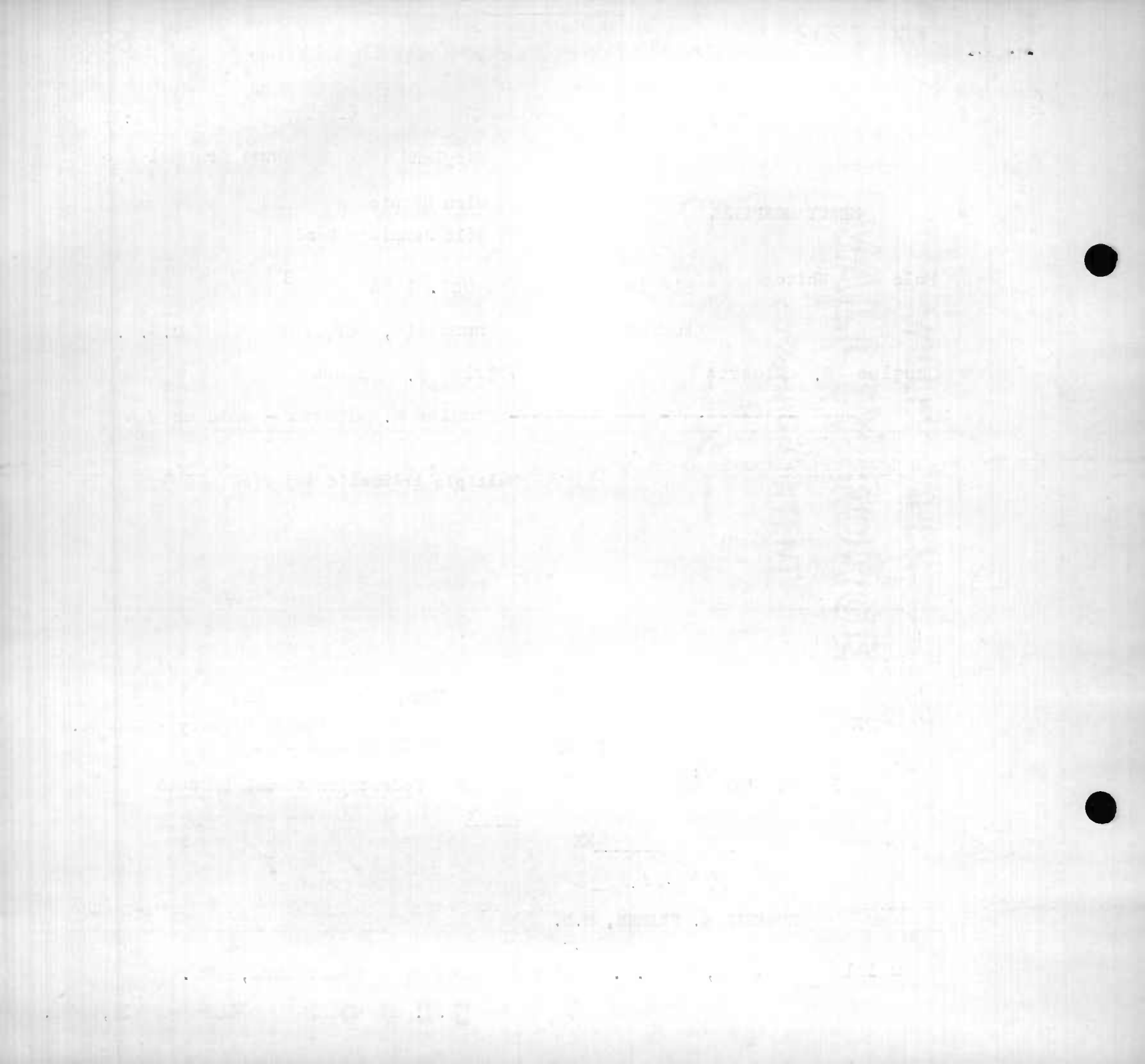
R. S. Fisher, M.D.

24C. FUNERAL DIRECTOR

J. R. SINGETON

ADDRESS

GLEN BURNIE, MD.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department									
BIRTH NO. 67 5203					CERTIFICATE OF DEATH		Registered No. 67 5203		
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>Frank Francis B. Williams</i>					5/29/67 CATM.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE <i>md.</i> B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					18-03				
D. STREET ADDRESS (If rural, give location)					836 W. Pratt St.				
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>		8. DATE OF BIRTH <i>1/22/1909</i>		9. AGE (In years last birthday) <i>58</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>Landscaper</i>		<i>Self Employed</i>		<i>md.</i>		<i>U. S. A.</i>			
13. FATHER'S NAME <i>Charles Williams</i>					14. MOTHER'S MAIDEN NAME <i>Mary E. Brogan</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>					16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Ms Willetta Williams</i> ADDRESS <i>above</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES					(A) DUE TO			1 yr.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO			2 mos.	
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>M</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> 19 <i>66</i> to <i>May 29</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>May 22</i> 19 <i>67</i> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>S. Munro</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>5/29/67</i>				
23C. PHYSICIAN'S NAME (Type) <i>Silvino B. Munro</i>					23D. ADDRESS <i>588 W. Lombard ST.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/1/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Landon Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>3801 Bedonick Ave</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 31 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Farkins</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan & Son Inc.</i>		25D. ADDRESS <i>281 St</i>			

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

122 W. Grant St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5204	
BIRTH NO. 67 5204				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) EDWARD VINCENT O'KEEFE, SR.			2. DATE AND HOUR OF DEATH MAY 28, 1967 8²⁰ A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Chiron Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 26-03 D. STREET ADDRESS (If rural, give location) 3413 BRENDAN AVE.		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 03-01-94	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10B. KIND OF BUSINESS OR INDUSTRY City Gov't.	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William O'Keefe			14. MOTHER'S MAIDEN NAME UNKNOWN Mabel Carroll		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 36 8354A	17. INFORMANT GERTRUDE E. O'KEEFE (wife)		ADDRESS same
18. 42011 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial INFARCTION			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			SEVERE CORONARY ARTERO- SCLEROSIS A.B. JENNY		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 25 19 67 to MAY 28 19 67 , that (I) (we) last saw the deceased alive on MAY 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James W. Carty Jr. M.D.				23B. DATE SIGNED 5/28/67	
23C. PHYSICIAN'S NAME (Type) JAMES W CARTY JR.		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR Philip F. Grech	
				ADDRESS 1211 Choseco Ave.	

Originals Interaction

SEVERE COGNATE ACTED -

STRESSING
AB FIRM

X

DATE: 10/10/10

DATE: 10/10/10

William O'Neil

WILLIAM O'NEIL

WILLIAM O'NEIL

WILLIAM O'NEIL

WILLIAM O'NEIL

WILLIAM O'NEIL

WILLIAM O'NEIL

WILLIAM O'NEIL

WILLIAM O'NEIL

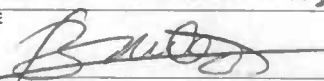
WILLIAM O'NEIL

WILLIAM O'NEIL

WILLIAM O'NEIL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5205	
BIRTH NO. 67 5205				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George P. Bender		5/27/67 7 ³⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hosp.				A. STATE Md.	
				B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 815 Hollins St.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/23/1912	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Missal Technician		10B. KIND OF BUSINESS OR INDUSTRY Martins Co.		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 553102200		17. INFORMANT Mrs Betty Bender
					ADDRESS above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) Hypertensive arteriosclerosis DUE TO heart disease (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 1966 to May 26 1967, that (I) last saw the deceased alive on May 26 1967 and that in (my) and opinion death occurred on the date and hour and from the causes stated above. (I) was (did) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 5/29/67	
23C. PHYSICIAN'S NAME (Type) BENIGNO M. OTEYZA				23D. ADDRESS 1012 Old North Point Rd., Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/1/67		24C. NAME OF CEMETERY or CREMATORY Lind Ridge Cem. Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR John J. Couranson Inc. 901 Hollins St. 23 Md.	

University of
the Pacific

University of
the Pacific

1912/1913

1912/1913

1912/1913

1912/1913

1912/1913

1912/1913

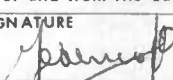
1912/1913

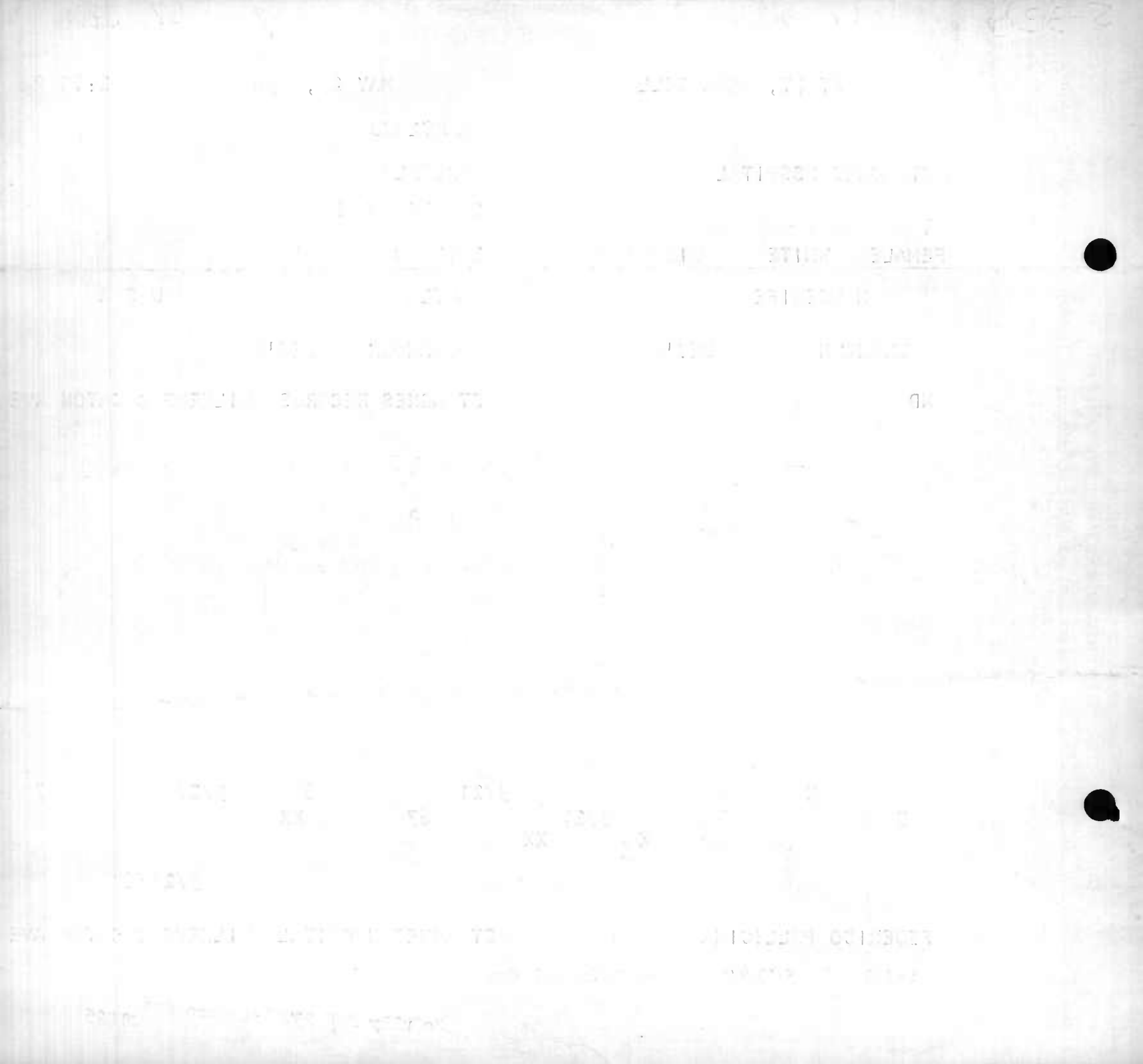
1912/1913

1912/1913

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5206	
BIRTH NO. 67 5206				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) STOUT, ANNA BELL			2. DATE AND HOUR OF DEATH MAY 27, 1967 2:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BROOKLYN C. CITY OR TOWN (If outside city limits, write RURAL and give township) 52-00 D. STREET ADDRESS (If rural, give location) 218 MEADOW RD		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	B. DATE OF BIRTH 2/12/88	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME UNKNOWN DEC'D			14. MOTHER'S MAIDEN NAME UNKNOWN DEC'D		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS ST AGNES RECORDS WILKENS & CATON AVE		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C. V. A. Streptococcus Mollitius			INTERVAL BETWEEN ONSET AND DEATH 6 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/27		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 5/21 19 67 to 5/27 19 67 , that (X) (we) last saw the deceased alive on 5/27 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) FEDERICO POLLICINA				23B. DATE SIGNED 5/27/67	
23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem	
24D. LOCATION Balto		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR McGully F. H. 237 Patapsco Ave 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 67 5207					CERTIFICATE OF DEATH					Registered No. 67 5207					
1. NAME OF DECEASED (Type or Print) <u>Hruz, John</u>										2. DATE AND HOUR OF DEATH <u>5/24/67</u> <u>1</u> <u>5</u> <u>A</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hosp</u>										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>Ba lto Co.</u>					
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Ba lto</u> <u>53-00</u>					
										D. STREET ADDRESS (If rural, give location) <u>127 Ventnor Terr.</u>					
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>		8. DATE OF BIRTH <u>11/24/09</u>		9. AGE (In years lost birthday) <u>57</u>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE MAN</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>					11. BIRTHPLACE (State or foreign country) <u>Ba lto MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>JOHN HRUZ</u>										14. MOTHER'S MAIDEN NAME <u>THERESA CHECK</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>213-09-0652</u>		17. INFORMANT <u>MRS MARY HRUZ</u>				ADDRESS <u>127 VENTNOR TERR</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>199.21</u> <u>MT</u> <u>carcinomatosis</u>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.															
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION <u>2</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>5/24/</u> <u>1967</u> to <u>5/24/</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>never</u> <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <u>L. J. Moglen</u> M.D.										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <u>L. J. Moglen</u> M.D.										23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>5/27/67</u>		24C. NAME of CEMETERY or CREMATORY <u>OAK LAWN</u>					24D. LOCATION (City, town, or county) (State) <u>BALTIMORE CO. MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 31 1967</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>					25C. FUNERAL DIRECTOR <u>ULLRKH FUNERAL HOME PUNDALIR MD</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5208		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5208	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VIRGIL SANTMYERS		2. DATE AND HOUR OF DEATH 5-27-67 5:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY U.S.A. Balto Co.			
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME + HOSPITAL BALTIMORE, MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53.00			
		D. STREET ADDRESS (If rural, give location) 1912 HERRITT BLVD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-10-08	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDING INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY ARCRODS CO.		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WASHINGTON SANTMYERS			
14. MOTHER'S MAIDEN NAME EMMA FISHER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			
16. SOCIAL SECURITY NO. 212-01-1539		17. INFORMANT Mrs. Virginia Santmyers (Wife) Same			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ✓	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 4-24 1967 to 5-27 1967, that (I) (we) last saw the deceased alive on 5-27-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. C. MARIANO		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-27-67	
23C. PHYSICIAN'S NAME (Type) J.C. MARIANO		23D. ADDRESS CHURCH HOME + HOSPITAL BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/31/67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY	
24D. LOCATION (City, town, or county) (State) COLGATE MD		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ULRICH FUNERAL HOME - DUNDALK MD			

for Virginia Southern

me

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5209				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5209	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Katherine Birkmaier</i>				2. DATE AND HOUR OF DEATH <i>May 24, 1967 10:00 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>48 Maryland General Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>26-01</i> D. STREET ADDRESS (If rural, give location) <i>5935 Kaven Ave</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>1/12/95</i>	9. AGE (In years last birthday) <i>72</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Weissing</i>			14. MOTHER'S MAIDEN NAME <i>Wilhelmina Knoll</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>John Birkmaier 8508 Westford Rd (son)</i>		
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <i>Arteriosclerotic Cardiovascular Di</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>May 24 1967</i> to <i>May 24 1967</i> , that (I) (we) last saw the deceased alive on <i>May 24 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>W. Michael Galt</i>				23B. DATE SIGNED <i>5/24/67</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. <i>Maryland General Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>5/27/67</i>	24C. NAME of CEMETERY or CREMATORY <i>PARKWOOD CEMETERY</i>		24D. LOCATION (City, town, or county) (State) <i>PARKVILLE MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 31 1967</i>		25B. NAME OF REGISTRAR <i>John B. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Edlrich 4210 Belair Rd.</i>			

May 24, 1912

Washing

Belt

21st Avenue

1/12 75

Washing

12

John (son)

At the Electric Car Wash

No.

May 24

May 24

May 24

2/24/12

X

Washing Car Wash

W. M. (signature)

FUNERAL DIRECTOR: IMPORTANT

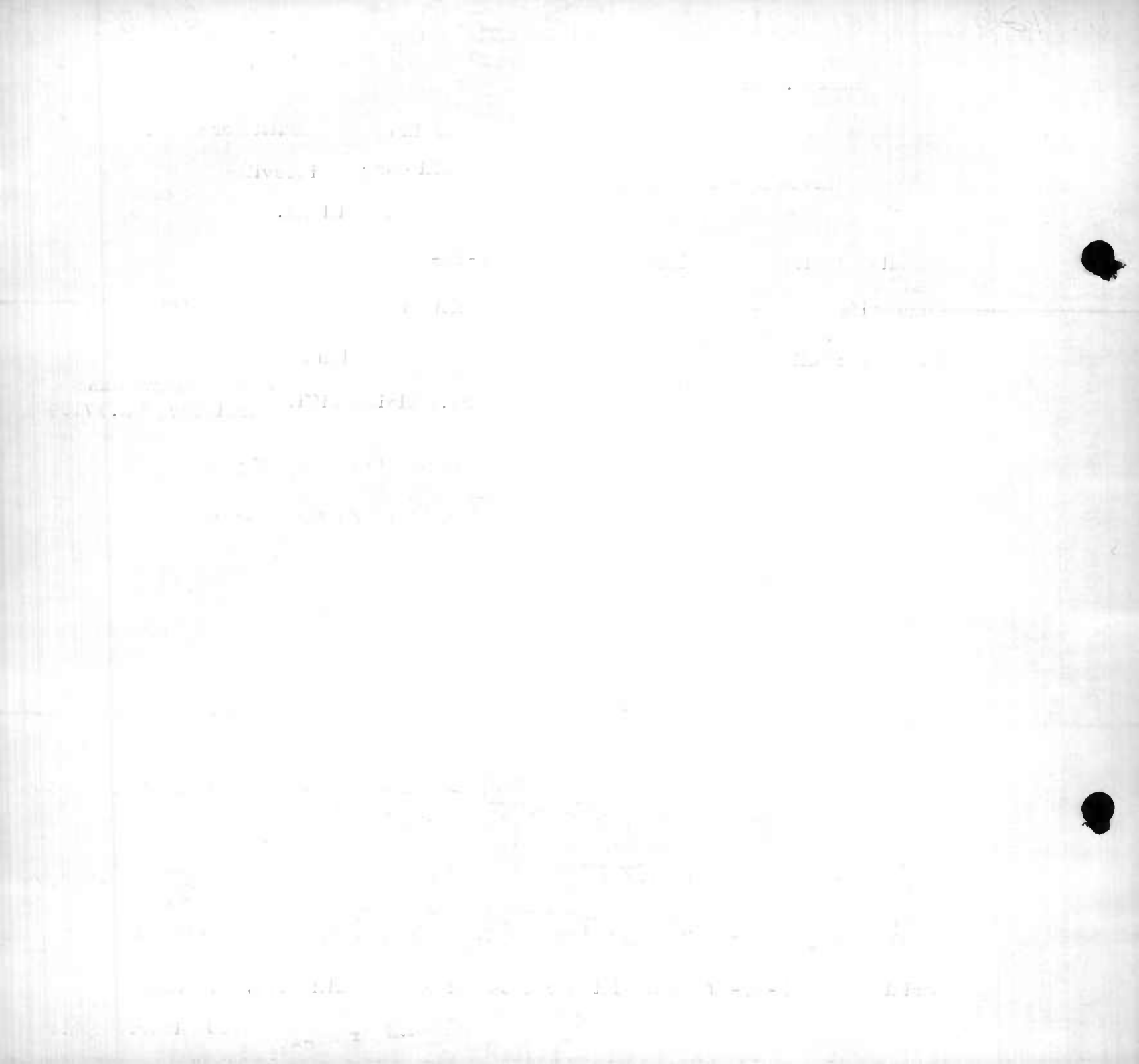
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5210		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5210	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDWINA SCHULTZ-SCHULZE		2. DATE AND HOUR OF DEATH MAY 26, 1967 7:00 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL 46 BALTIMORE, MARYLAND 6-6-67		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 6872 Parsons Avenue # 7			
5. SEX Female	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-2-1901	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME William Schulze		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-01-3164A		17. INFORMANT A Carlton L. Dwyer-6872 Parsons Ave.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) Arterio Sclerotic Cardiovascular Disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 24 hours.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/25/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hiatus Hernia		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/4/67 19 to 5/26/67 19 that (I) (we) last saw the deceased alive on 5/26/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angel H. Roque		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/26/67	
23C. PHYSICIAN'S NAME (Type) ANGEL H. ROQUE		23D. ADDRESS LUTHERAN HOSPITAL, BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-29-67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			
25B. NAME OF REGISTRAR Dorothy E. Collins		25C. FUNERAL DIRECTOR Ellsworth Armacost -4600 Liberty Hghts.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

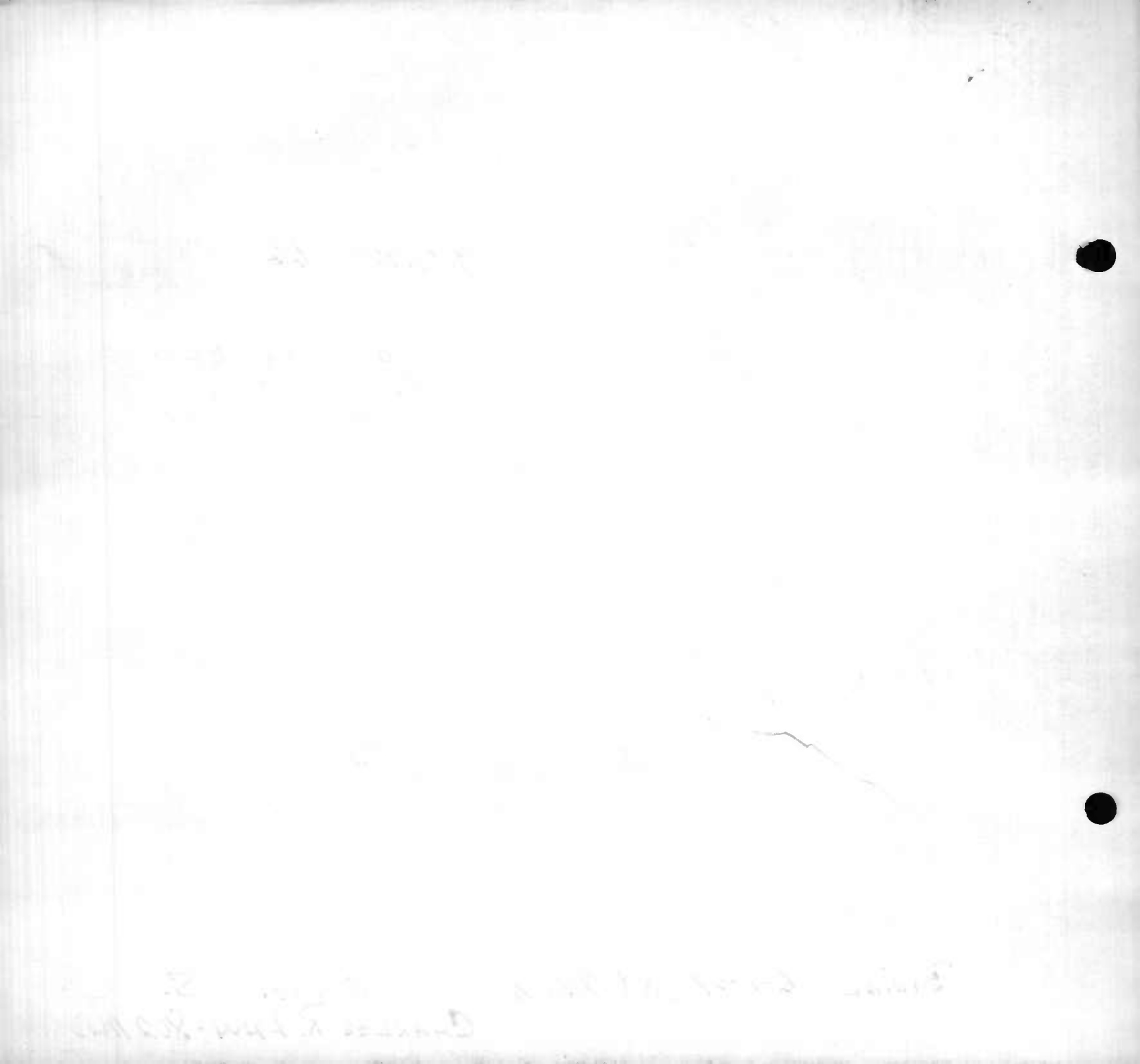
BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 67 5211	
BIRTH NO. 67 5211				DATE AND HOUR OF DEATH 5/27/67	
1. NAME OF DECEASED (Type or Print) Anna D. Walker					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Haven Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Pikesville 53-00 D. STREET ADDRESS (If rural, give location) Rosehill Rd.	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-10-1881	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James McNally			14. MOTHER'S MAIDEN NAME Flynn		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Melvin Griffith	
				ADDRESS 3104 Meadow Lane Harrisburg Pa. 17109	
18. 450.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Insufficiency of age ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-19-60 to 5-26-67 that (I) (we) last saw the deceased alive on 9-25-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Thomas G. Abbott M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5-29-67	
23C. PHYSICIAN'S NAME (Type) Thomas G. Abbott M.D.				23D. ADDRESS 4509 Liberty Hgts. Baltimore	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-29-67		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Ellsworth Armacost	
				ADDRESS 4600 Liberty Hgts	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5212	
BIRTH NO. 67 5212				Registered No. 67 5212	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY PROCTOR			2. DATE AND HOUR OF DEATH 5/27/67 15:49 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL 38			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALT C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT D. STREET ADDRESS (If rural, give location) 2301 Ocala		
5. SEX F	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	B. DATE OF BIRTH 9/6/1900	9. AGE (In years last birthday) 66	11. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME NATHANIEL MARION		
14. MOTHER'S MAIDEN NAME LUCINDA Mc BURKLIN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS SIDNEY W TIESENGA NO. 7469 FURNACE BR RD GLEN BURNIE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 153.11			CAUSE OF DEATH (A) Prophylactic suppurative infection DUE TO (B) Metastatic cancer of transverse colon DUE TO (C) > 3 months		
INTERVAL BETWEEN ONSET AND DEATH 2 minutes away			ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/3/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of colon		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5 PM 5/27 19 67 to 5:45 PM 5/27 19 67 , that (I) (we) last saw the deceased alive on 5:45 PM 5/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney W Tiesenga				23B. DATE SIGNED 5/27/67	
23C. PHYSICIAN'S NAME (Type) SIDNEY W. TIESENGA				23D. ADDRESS 7469 FURNACE BRANCH RD GLEN BURNIE MARYLAND	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-1-67		24C. NAME of CEMETERY or CREMATORY St. Mark	
24D. LOCATION (City, town, or county) (State) SIMPSON S. C.		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			
25B. NAME OF REGISTRAR R. L. E. Fisher		25C. FUNERAL DIRECTOR ADDRESS CHARLES R. LAW - 802 MADISON AVE			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67-5213BIRTH NO. 5213

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WENDELL CLARK

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

10:25 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3515 Reisterstown Road 21215

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 11, 1938

9. AGE (In years last birthday)

29

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Clark

14. MOTHER'S MAIDEN NAME

Vivian Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Vivian Clark, 3515 Reisterstown Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hematoma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

In front of 3539 Park Heights

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 5 15 '67 12:30 AM

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Presumably fell -

striking head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-28-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

5-31-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 31 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.

FUNERAL DIRECTOR: IMPORTANT

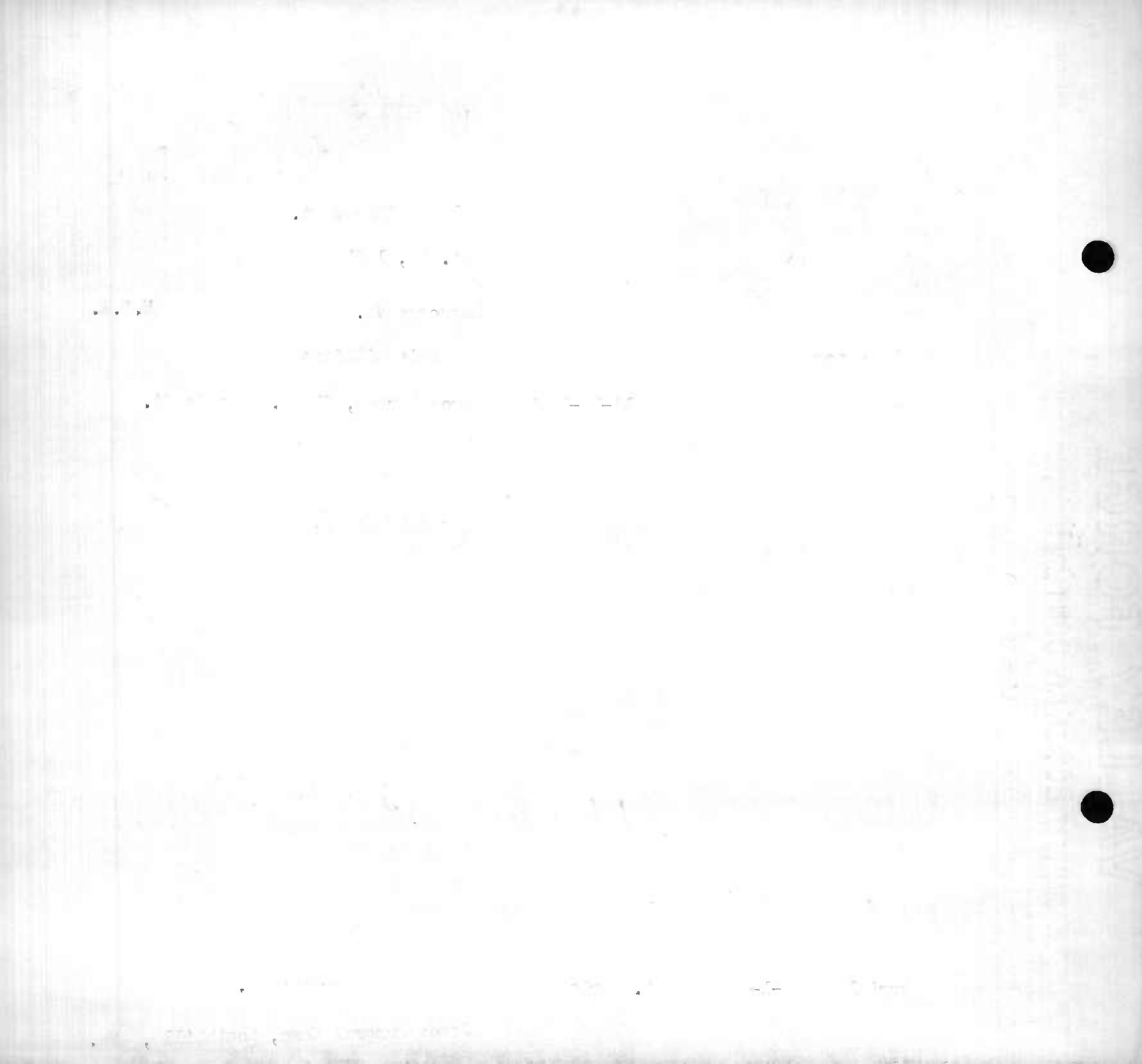
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5214	
BIRTH NO. 67 5214				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) KAREN SMALL				2. DATE AND HOUR OF DEATH 5-29-67 8:50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTABELLO STATE HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3016 W. LANVALE ST.	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH Feb. 19, 1948	9. AGE (In years last birthday) 19
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Small		
14. MOTHER'S MAIDEN NAME Geneva Robinson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		
16. SOCIAL SECURITY NO.			17. INFORMANT Geneva Small, 3016 W, Lanvale St.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH (A) Pulmonary Embolus 1 day (B) Quadriplegia 3 YEARS (C) Meningioma, cervical cord 6 YEARS		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Decubitus Ulcers 3 YEARS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>6-10 1964</u> to <u>5-29 1967</u>, that (X) (we) last saw the deceased alive on <u>5-29 1967</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Irving L. Cooperstein M.D.				23B. DATE SIGNED 5-29-67	
23C. PHYSICIAN'S NAME (Type) IRVING L. COOPERSTEIN M.D.				23D. ADDRESS MONTABELLO HOSP. BALTO., MD.	
24A. BURIAL CREMATION (Specify) Burial		24B. DATE 6-1-67		24C. NAME OF CEMETERY or CREMATORY Arbutus	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			
25B. NAME OF REGISTRAR Charles R. Law		25C. FUNERAL DIRECTOR Charles R. Law, 802 Madison Ave.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5215	
BIRTH NO. 67 5215		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Gordon Grace		2. DATE AND HOUR OF DEATH 27 May 67 11:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 15-01			
FULL NAME OF HOSPITAL OR INSTITUTION Univ Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md.			
		D. STREET ADDRESS (If rural, give location) 1609 Gilmore St.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH Sept. 21, 1922	9. AGE (In years last birthday) 44	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lacrosse Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hack Wesson		14. MOTHER'S MAIDEN NAME Annie Williams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-20-8389		17. INFORMANT ADDRESS Aaron Gordon, 522 W. Lanvale St.	
18. 331X I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Subarachnoid Hemorrhage		3 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Hypertension			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 27 May 1967 to 27 May 1967 , that (I) (we) last saw the deceased alive on 1 P.M. 27 May 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 27 May 67	
23C. PHYSICIAN'S NAME (Type) John W. Eickhoff		23D. ADDRESS Univ Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-1-67		24C. NAME OF CEMETERY or CREMATORY St. Marks	
24D. LOCATION (City, town, or county) (State) Lacrosse Va.					
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Jones Funeral Home, Southhill, Va.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5216		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5216	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WALTER KOPCZENSKI		2. DATE AND HOUR OF DEATH 5/29/67 10.00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GEN. HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 1-04		
D. STREET ADDRESS (If rural, give location) 2310 Cambridge St. 21224					
5. SEX MA.	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 9/22/94	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME John KOPCZENSKI			14. MOTHER'S MAIDEN NAME ALEXANDRA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-0678		17. INFORMANT ROBERT ROSENOFF	
18. 720.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC HEART D'S		CAUSE OF DEATH (A) ARTERIOSCLEROTIC HEART D'S DUE TO (B) Pulmonary Emphysema DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/29/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (the) (this hospital) attended the deceased from 5/29 19 67 to 5/29 19 67 , that (we) (we) last saw the deceased alive on 5/29 19 67 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Rosenoff				23B. DATE SIGNED 5/29/67	
23C. PHYSICIAN'S NAME (Type) DR NIZWIK		23D. ADDRESS 2724 N. CHARLES ST			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/2/67		24C. NAME OF CEMETERY ST. STANISLAUS	
24D. LOCATION (City, town, or county) BALTIMORE, MD					
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR George A. Weber	
25D. ADDRESS 705 SOUTH ANN ST					

21-03-12

140

1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5217		CERTIFICATE OF DEATH		67 5217	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ELLA HUDNET		2. DATE AND HOUR OF DEATH 5-27-67 8:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME & HOSP.		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 2504	
		D. STREET ADDRESS (If rural, give location) 111 Riverside Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH Aug 8-1890	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME WM. MC LAUGHLIN		14. MOTHER'S MAIDEN NAME SARAH CHESTER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT WM. T. HUDNET 111 RIVERSIDE ROAD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Staphylococcal Septicemia BRONCHO PNEUMONIA EMPHYEMA (Left)		INTERVAL BETWEEN ONSET AND DEATH days			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II Brandopneumonia; Rheumatic Arthritis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-17 to 5-27 19 67 and that (I) (we) last saw the deceased alive on 5-27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodolfo M. Lim M.D.				23B. DATE SIGNED 5-27-67	
23C. PHYSICIAN'S NAME (Type) Rodolfo M. Lim M.D.				23D. ADDRESS Church Home & Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/31/67		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY COLONATE MD	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR R. E. E. Taylor, M.D.		25C. FUNERAL DIRECTOR ULLRICH FUNERAL HOME 4210 BELAIR	

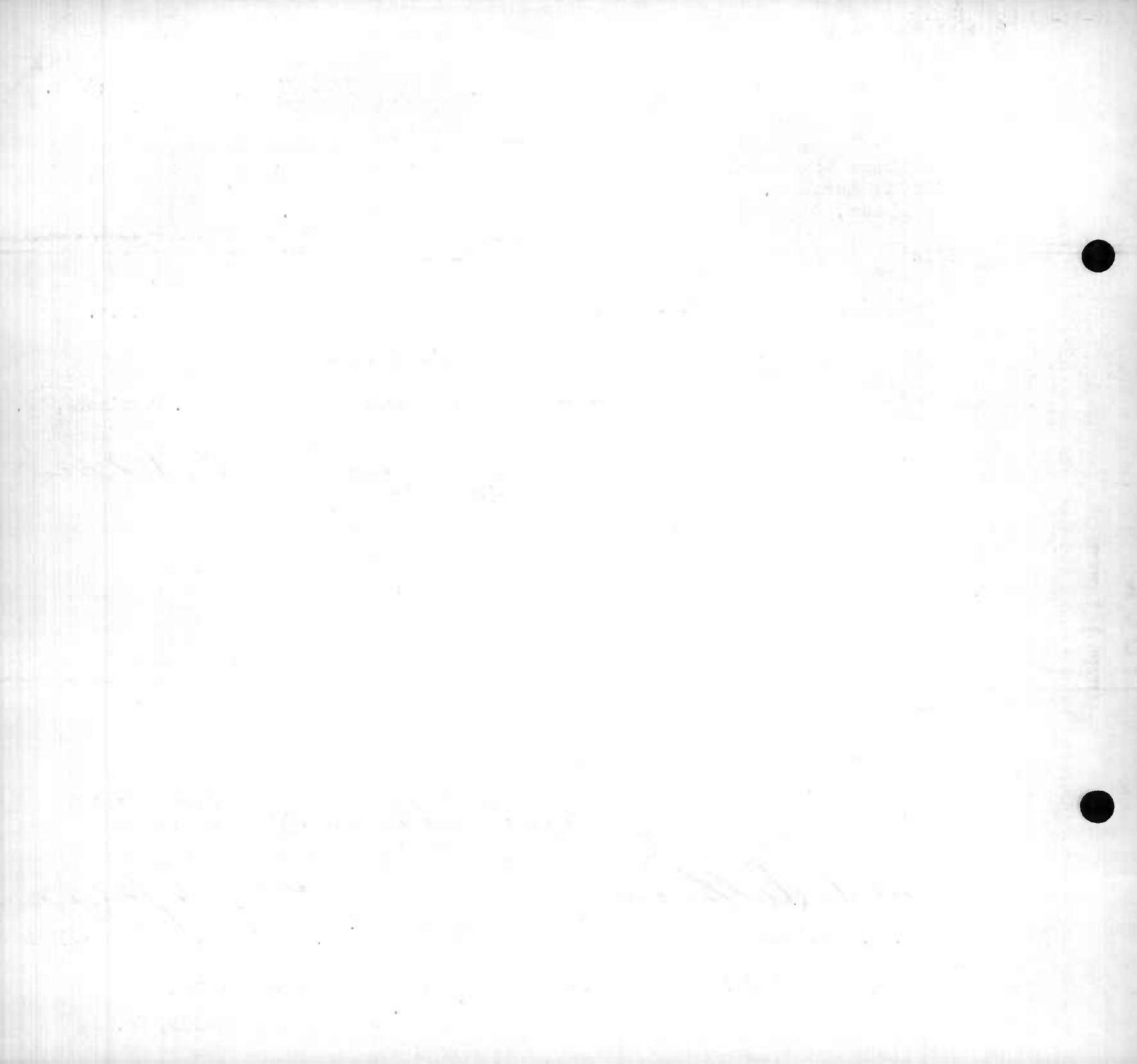
BRONCHO ENZYME
(1974)

CERTIFICATE OF DEATH

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 17-250 67 5218		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) EUGENE MAKIN		2. DATE AND HOUR OF DEATH 5/26/67 4:10 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.	
5. SEX Male		6. RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 9-24-98	
9. AGE (In years lost birthday) 68		10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic,		10B. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Makin		14. MOTHER'S MAIDEN NAME Sadie Matthew	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 084-05-6196	
17. INFORMANT BCH: Records 4940 Eastern Ave. Baltimore, Md.		ADDRESS #21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarct ASCVD INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 5/26/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5/26/67 19 to 5/26/67 19 that (1) (we) lost saw the deceased alive on 5/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M. A. Sullivan		23B. DATE SIGNED 5/26/67	
23C. PHYSICIAN'S NAME (Type) M. A. Sullivan		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR R. E. E. E. E. E.	
25C. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5219		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5219	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mabel F. Rannalls		2. DATE AND HOUR OF DEATH 5/28/67 6 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY WEST VIRGINIA			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33		C. CITY OR TOWN (If outside city limits, write RURAL and give township) ROMNEY V-45			
		D. STREET ADDRESS (If rural, give location) 40 East Birch Lane			
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-16-00	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home-maker		10B. KIND OF BUSINESS OR INDUSTRY Retired School Teacher		11. BIRTHPLACE (State or foreign country) Hampshire County, W.Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CHARLES XXXXX NEWMAN		14. MOTHER'S MAIDEN NAME NANNIE ELIZABETH FIELDS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 235-60-3038-A		17. INFORMANT J. Howard Rannells 40 E. Birch Lane Romney, W. Va.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO Congestive heart failure (B) DUE TO Aortic stenosis (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH 1 yr 9 yrs 10-15 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/27		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5/20 19 67 to 5/28 19 67, that (2) (we) lost saw the deceased alive on 5/27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE e. P. Wilkinson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/28/67	
23C. PHYSICIAN'S NAME (Type) C.P. Wilkinson		23D. ADDRESS JMH			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-30-67		24C. NAME of CEMETERY or CREMATORY Indian Mound Cemetery	
24D. LOCATION Romney, Hampshire Co., W.Va.					
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Byron Knight, 309 Decatur Street Cumberland, Md.	

10-11-44

Completed test table
Harris & Harris
Harris

yes

C. P. W. H. H. H.
C. P. W. H. H. H.

11/11

11/11

11/11

11/11

11/11

11/11

R-324

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5220

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES L. RIDGELY III

2. DATE AND HOUR PRONOUNCED DEAD

May 26, 1967 1:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY QUEEN ANNES

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

CHESTER

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

10-4-1918

9. AGE (In years
last birthday)

48

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

OFFICE SUPERVISOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALT. MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JAMES R. RIDGELY

14. MOTHER'S MAIDEN NAME

MARJORIE JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. JAMES L. RIDGELY 3RD - CHESTER

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

highway

21C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR? Baltimore-Washington
Expressway - 528 ft. south of Annapolis
cutoff21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

5-26-67

1:00 A.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Driver in auto-auto collision

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Charles S. Springate
Charles S. Springate, M.D.CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

MAY 28

23C. NAME of CEMETERY or CREMATORY

STEVENS VILLE

23D. LOCATION (City, town, or county)

STEVENS VILLE

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

MAY 31 1967

24B. NAME OF REGISTRAR

George E. Hall

24C. FUNERAL DIRECTOR

Edgar A. Lane

ADDRESS

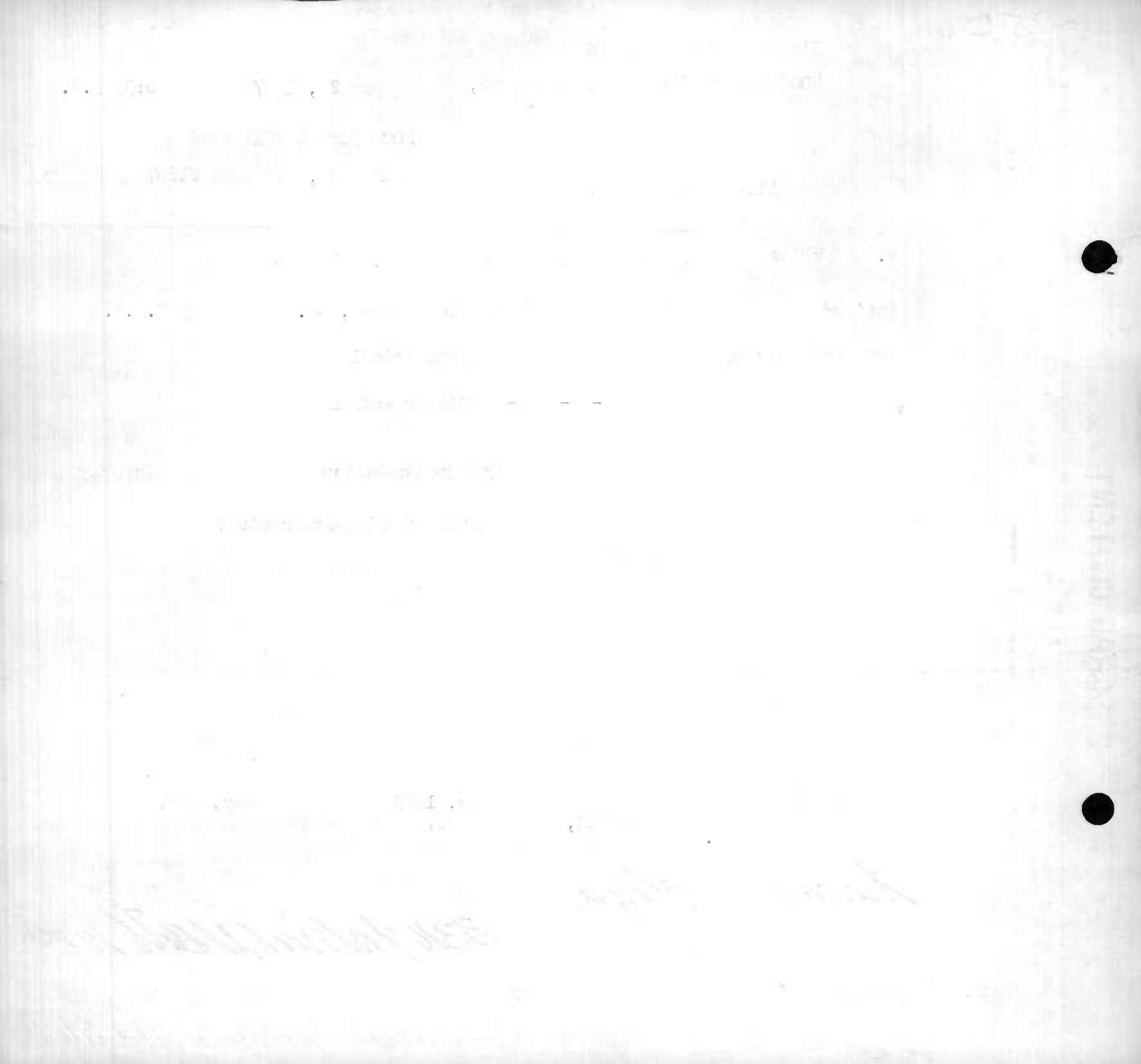
CHURCH HILL MD.

10-1-1918
DART MARRIAGE
MARSHALL JONES
MARSHALL JONES

Office Supervisor
James R. Jones
Wm. H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5221	
BIRTH NO. 67 5221		Sister Gertrude Sagona		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		4000 Forest Hill Road, Baltimore,		May 28, 1967 6:35 P.M. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
94 Villa Saint Michael		4000 Forest Hill Road			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore, Maryland 21207 28-41			
		D. STREET ADDRESS (If rural, give location)			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F.	White	never married	January 14, 1872	95	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Retired		Sister of Charity	New Orleans, La.	U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Epiphania Sagona			Anna Tricolo		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-54-0682-JI		Sister Andrea	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		One day	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from May, 1959 to May, 1967 that (I) (we) lost saw the deceased alive on May 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		25-29-67	
		M.D. 336 Frederick Rd. Bldg 29 Md			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	May 30/67	Seton	6430 Ruspers Road Rd 21215		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
MAY 31 1967	G. E. E. Taylor, M.D.	Shubert Mortuary		10810 Park	



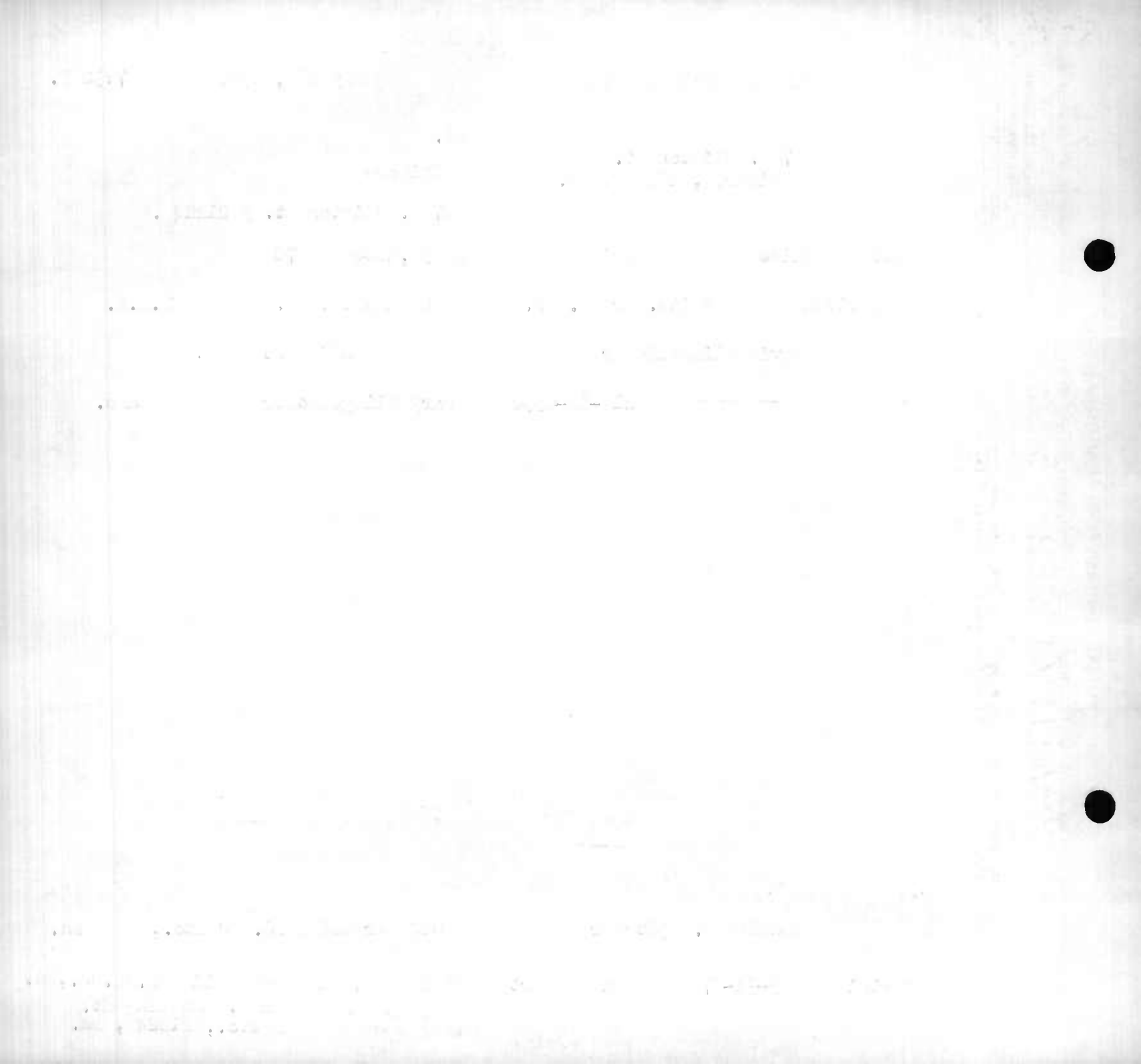
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 67 5222				MAY 27, 1967		2:50 A.M.	
M.E. CASE NO.				NAME OF DECEASED		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Harriet B. Cunningham				2. DATE AND HOUR OF DEATH May 27, 1967 2:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing Center 1400 John Street Baltimore, Maryland				A. STATE Maryland			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
Baltimore				301 McMechen St. 21217			
5. SEX Female		6. RACE Caucasian		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 3-30-95	
9. AGE (In years lost birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance clerk		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Broch				14. MOTHER'S MAIDEN NAME Phoebe Murphy			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 175-14-5448		17. INFORMANT Harry C. Cunningham Box 198 Rt 1 Sykesville Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II				19. CAUSE OF DEATH Torenia due to bed area following penning of fracture right hip arteriosclerotic heart disease		20. INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. see attached sheet.			
23A. DATE OF OPERATION 5-29-67		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED		24A. AUTOPSY? (Yes or No) No		24B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
25A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		25C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Cutaway Place + McMechen St		25D. HOW DID INJURY OCCUR? Step off of bus into mud hole	
26A. TIME OF INJURY (APPROX.) 3-8-67 2:30 PM		26B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		26C. I certify that (I) (this hospital) attended the deceased from 5/19 1967 to 5/27 1967 , that (I) (we) lost saw the deceased alive on 5/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
27A. SIGNATURE ALLAN H. MACHT				27B. DATE SIGNED 5/27/67			
28A. PHYSICIAN'S NAME (Type) ALLAN H. MACHT				28B. ADDRESS 2 E. Red St Balt, Md 21202			
29A. BURIAL CREMATION, REMOVAL (Specify) Burial		29B. DATE 5/29/67		29C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Wash.		29D. LOCATION (City, town, or county) (State) Blacksburg, Va Howard Co	
30A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		30B. NAME OF REGISTRAR W. E. Sullivan		30C. FUNERAL DIRECTOR Strong Byers & Pandall		30D. ADDRESS 8728 Liberty Rd Md	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5223	
BIRTH NO. 67 5223		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES KLINGELHOFFER						2. DATE AND HOUR OF DEATH May 28, 1967		7:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location) 507 S. Clinton St. Baltimore, 21224, Md.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
						D. STREET ADDRESS (If rural, give location) 507 S. Clinton St. # 21224.					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH June 5, 1888		9. AGE (In years last birthday) 78		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Balto. Trans. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME David Klingelhofer						14. MOTHER'S MAIDEN NAME Elizabeth ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-0996		17. INFORMANT Mary Klingelhofer		ADDRESS Same.					
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Coronary occlusion (B) DUE TO ARTERIOSCLEROTIC HEART DISEASE (C) _____						INTERVAL BETWEEN ONSET AND DEATH 20 minutes 5 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CEREBRO VASCULAR THROMBOSIS						1 mo			
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from Feb 1, 1963 to May 25, 1967, that (I) (we) last saw the deceased alive on May 24, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.											
23A. SIGNATURE Randolph H. Spitzberg		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED May 30, 1967							
23C. PHYSICIAN'S NAME (Type) Randolph H. Spitzberg		M.D.		23D. ADDRESS 6024 Berkeley Rd. Balto., Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-67		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd. Ba. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Charles E. Fisher		25C. FUNERAL DIRECTOR Charles E. Fisher		25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5224		CERTIFICATE OF DEATH		67 5224	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		MCCausland, ALVIN		MAY 25, 1967 10 ⁰⁵ P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOUSE IN THE PINES BELAIR 5837 Belair Road #6. 90 BALTIMORE, MARYLAND		31 LANBOORNE ROAD BPTD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, Md - #4 Balt.	
D. STREET ADDRESS (If rural, give location)		53-00			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 11-22-96	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MECHANIC		RAILROAD		MACKTON, MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
MARCUS McCausland		ELLEN CUNNINGHAM		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		714-05-6926		HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) CEREBROVASCULAR HEMORRHAGE		12.24 hr.	
ANTECEDENT CAUSES		(B) HYPERTENSIVE VASCULAR DISEASE		YEARS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) SENILE DEMENTIA		SEVERAL YEARS	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from APRIL 1966 to MAY 25 1967, that (I) (we) last saw the deceased alive on MAY 24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William L. Fearing				5-27-67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WILLIAM L. FEARING		3025 BELAIR ROAD, BALT-13MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		5-29-67		SLATE RIDGE	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR ADDRESS			
DELTA YORK CO. PA.		John H. Barkins, DELTA, PA.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 31 1967		John E. Barkins		John H. Barkins, DELTA, PA.	

70

ALBERTA
FREDERICK

MICHAEL
MICHAEL

11

11

11

ALBERTA
FREDERICK

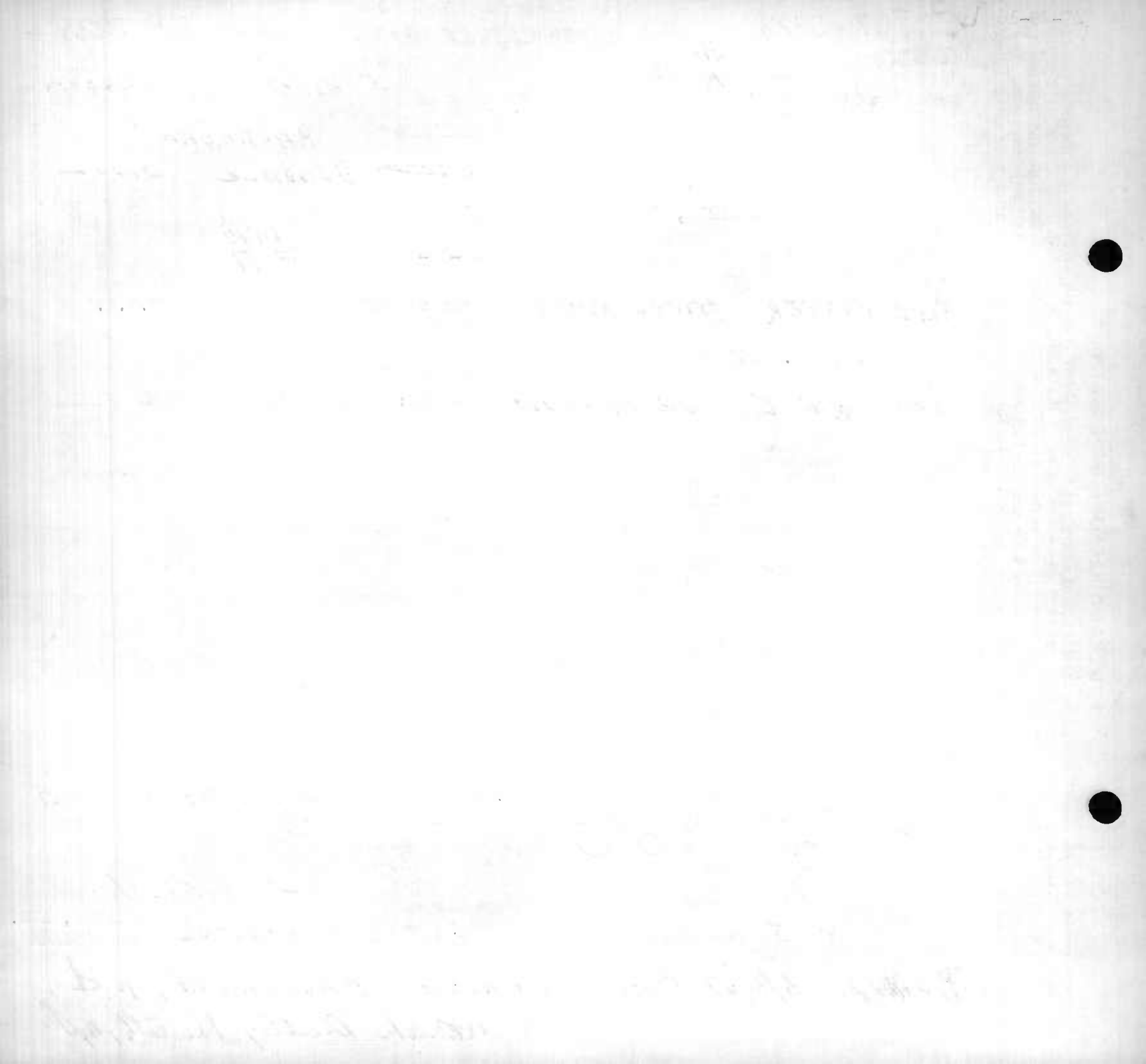
CERTIFICATE OF DEATH

Registered No. 67 5225

BIRTH NO. 67 5225		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) ORLANDO DIGGINS		2. DATE AND HOUR OF DEATH 5/27/67 12:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE DUNDALK 31222 D. STREET ADDRESS (If rural, give location) 3129 CORNWALL ROAD 53-00	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-18-95
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER		10B. KIND OF BUSINESS OR INDUSTRY STEEL MFR	9. AGE (In years, lost birthday) 71
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. DIGGINS		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I 218-07-5204		16. SOCIAL SECURITY NO.	
17. INFORMANT RECORDS: BCM 4940 EASTERN AVENUE #21224		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, 10 days OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT, 10 days		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5/17/67 19 67 to 5/27 19 67 , that (1) (we) last saw the deceased alive on 5/27 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE P. J. McLEOD		23B. DATE SIGNED 5/27/67	
23C. PHYSICIAN'S NAME (Type) P. J. McLEOD		23D. ADDRESS BALT. CITY HOSPITAL #21224, AVE. 4940 EASTERN	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/31/67	
24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR P. J. McLEOD	
25C. FUNERAL DIRECTOR W. B. Dudley, Dundalk, Md.		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

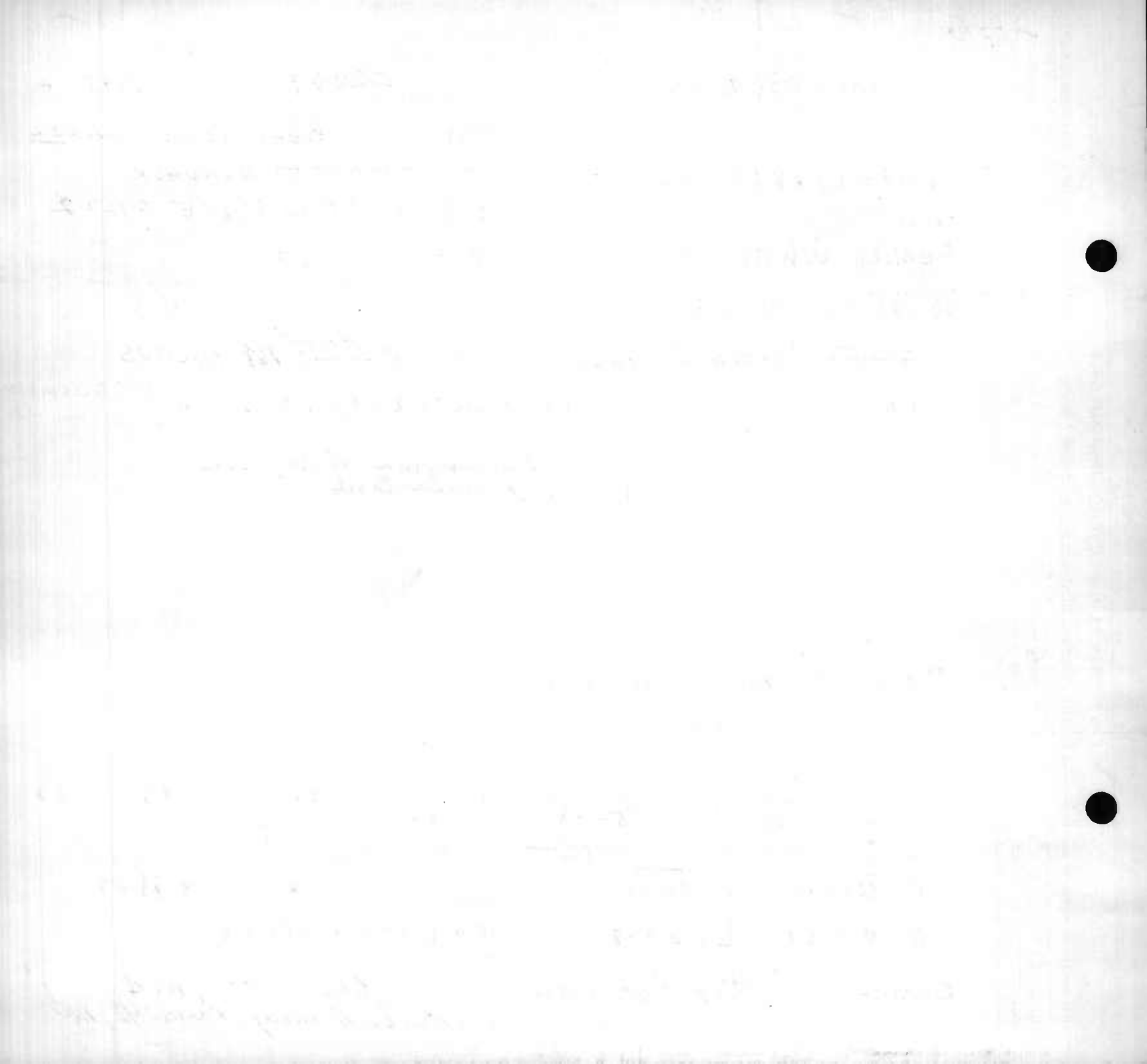
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

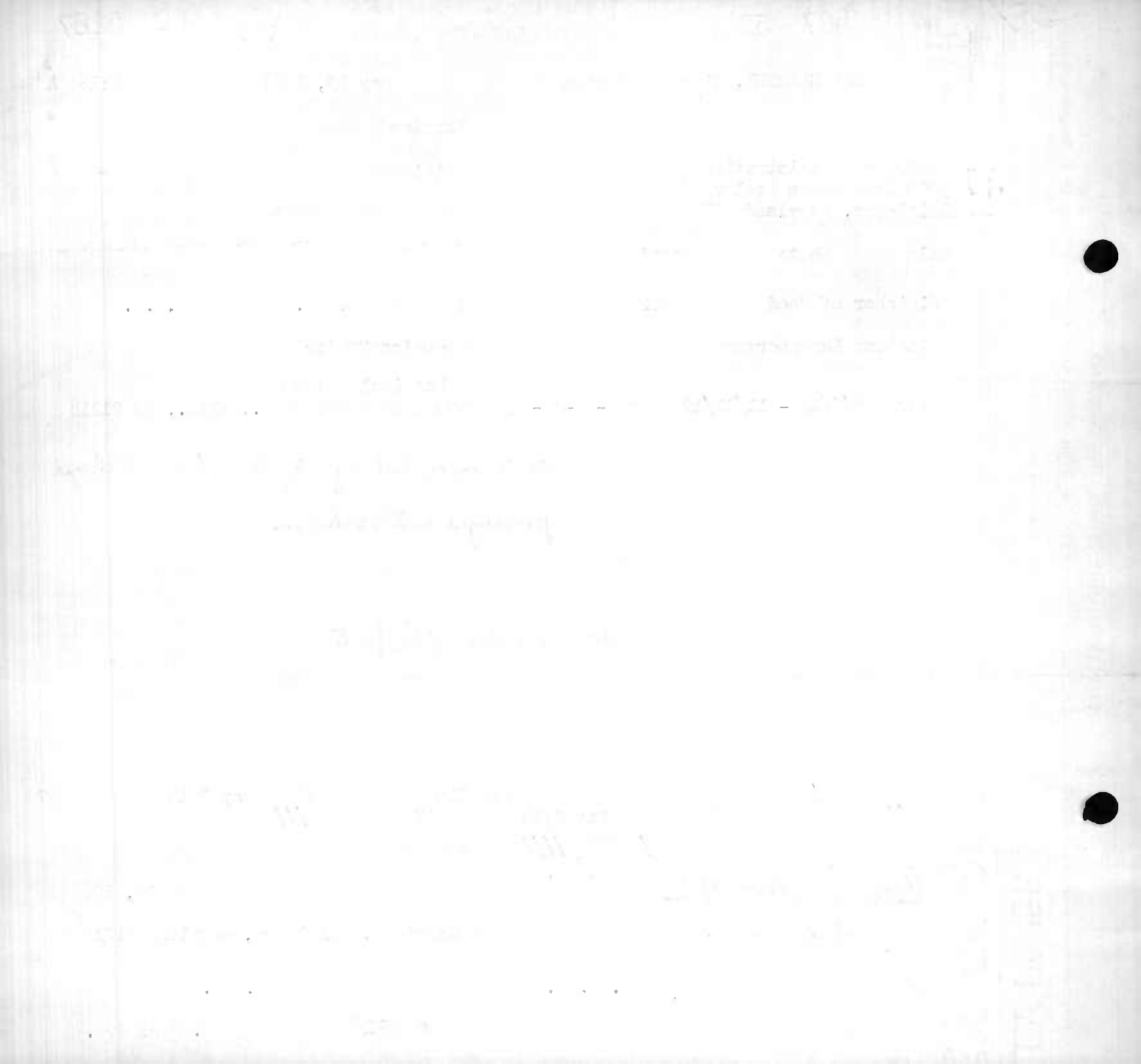
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 5226				
BIRTH NO. 67 5226									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) THE RESAM. HISLEY					2. DATE AND HOUR OF DEATH 5-28-67 7:45 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GEN. HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE DUNDALK 53-00 D. STREET ADDRESS (If rural, give location) #3 CENTER PLACE 2122				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 7-23-03	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINCIPAL - SCHOOL BOARD OF EDUCATION MARYLAND			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSEPH E. HISLEY					14. MOTHER'S MAIDEN NAME ANNA ROEFUS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 220-268987		17. INFORMANT SISTER - MRS. A.G. BUSH		ADDRESS 610 BELLINKAM CT.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the ovary with metastasis					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2-24-67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL PAIN + MASS			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-24-67 to 5-28-67 , that (I) (we) last saw the deceased alive on 5-28-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Melvinis Ventura					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 5-28-67	
23C. PHYSICIAN'S NAME (Type) BENIGNO LAZARO					23D. ADDRESS 1819 EUTAW PLACE				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 5/31/67			24C. NAME OF CEMETERY or CREMATORY OAK LAWN			24D. LOCATION (City, town, or county) (State) BALTO. CO. MD.
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			25B. NAME OF REGISTRAR Robert E. [unclear]			25C. FUNERAL DIRECTOR W.S. Bucke Bradley, Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5227	
BIRTH NO. 67 5227		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LUXENBERGER, Clarence George		2. DATE AND HOUR OF DEATH May 29, 1967 7:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23-01 D. STREET ADDRESS (If rural, give location) 106 Burnett Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/22/97	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finisher of Wood		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Williamsport, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Anthony Luxenberger		14. MOTHER'S MAIDEN NAME Catherine Bender	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/5/17 - 11/11/19		16. SOCIAL SECURITY NO. 216-03-34-81		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) acute myocardial infarct with rupture ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. generalized arteriosclerosis		CAUSE OF DEATH (A) acute myocardial infarct with rupture (B) generalized arteriosclerosis (C)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. gangrene, dry, of foot					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 11th 19 67 to May 29th 19 67 , that (I) (we) last saw the deceased alive on May 29th 19 67 and that in (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Circle Crisler, M.D.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 29, 1967	
23C. PHYSICIAN'S NAME (Type) CIRCLE CRISLER,		23D. ADDRESS M.D. VA Hospital, Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 1 1967		24C. NAME OF CEMETERY or CREMATORY Balto. U. S. National	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Farley	
25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5228	
BIRTH NO. 67 5228		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Theodore Newton Leef		2. DATE AND HOUR OF DEATH MAY 28, 1967 5:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
		D. STREET ADDRESS (If rural, give location) 2838 LAKE AVENUE #13		8-01	
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 09-03-89	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Leef		14. MOTHER'S MAIDEN NAME Blanche UNKNOWN ALLMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. GRACE LEEF (WIFE)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-20-11		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 25 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO MYOCARDIAL infarction			
		(B) DUE TO ARTERIOSCLEROTIC CARDIO - ? years			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 3, 1967 to MAY 28, 1967 , that (I) (we) last saw the deceased alive on MAY 28, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE James W. Carty Jr.				23B. DATE SIGNED 5/28/67	
23C. PHYSICIAN'S NAME AND ADDRESS DR. JAMES W. CARTY JR.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/67		24C. NAME OF CEMETERY or CREMATORY Hampstead Cemetery	
24D. LOCATION Hampstead, Md.		24E. DATE REC'D BY HEALTH DEPT. MAY 31 1967		24F. NAME OF REGISTRAR John E. Taylor	
24G. DATE REC'D BY HEALTH DEPT. MAY 31 1967		24H. NAME OF REGISTRAR John E. Taylor		24I. FUNERAL DIRECTOR Schimmek Funeral Home	
24J. ADDRESS 3331 Brehms Lane #13		24K. ADDRESS		24L. ADDRESS	

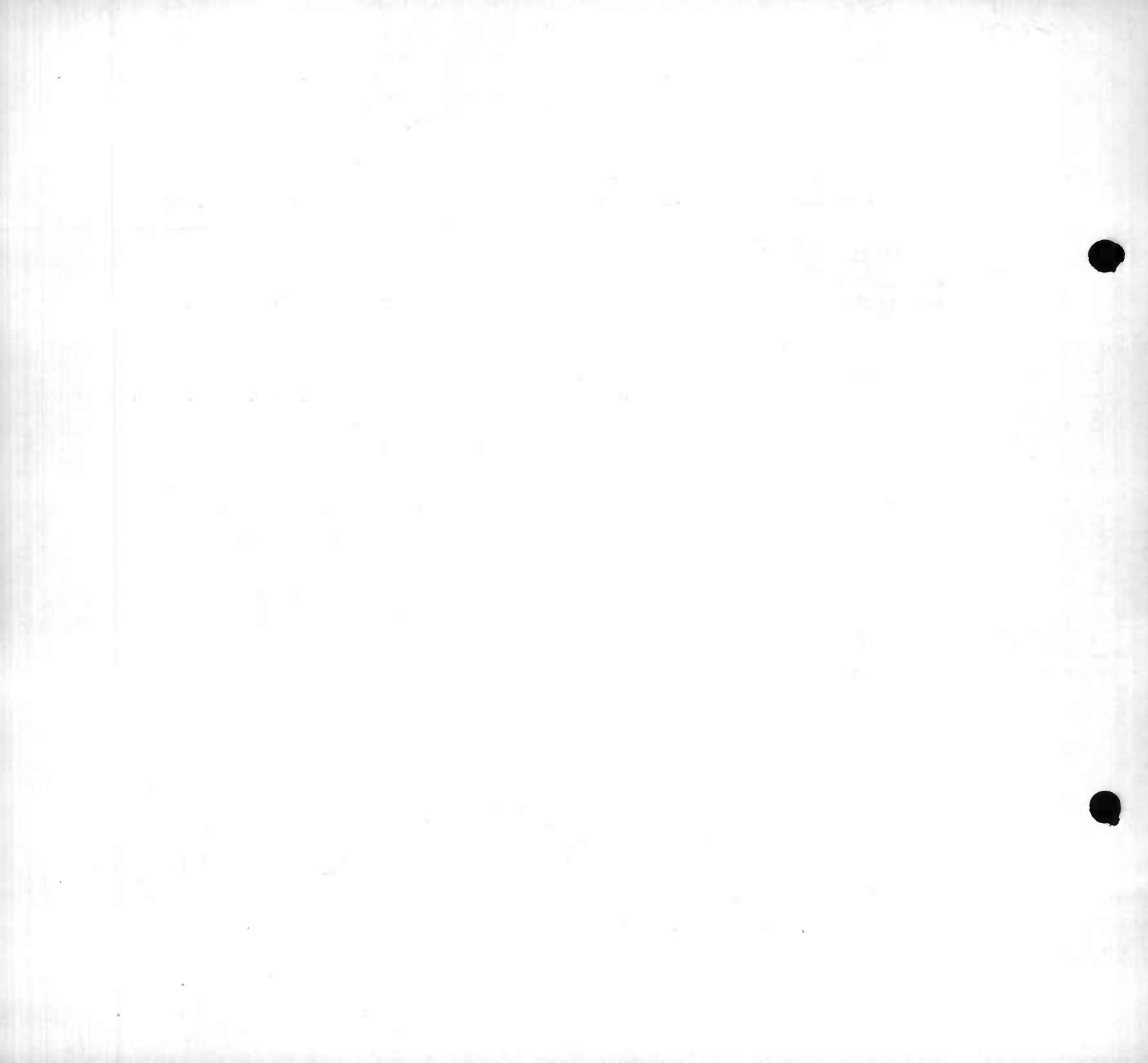
THE UNITED STATES OF AMERICA

100-100000-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

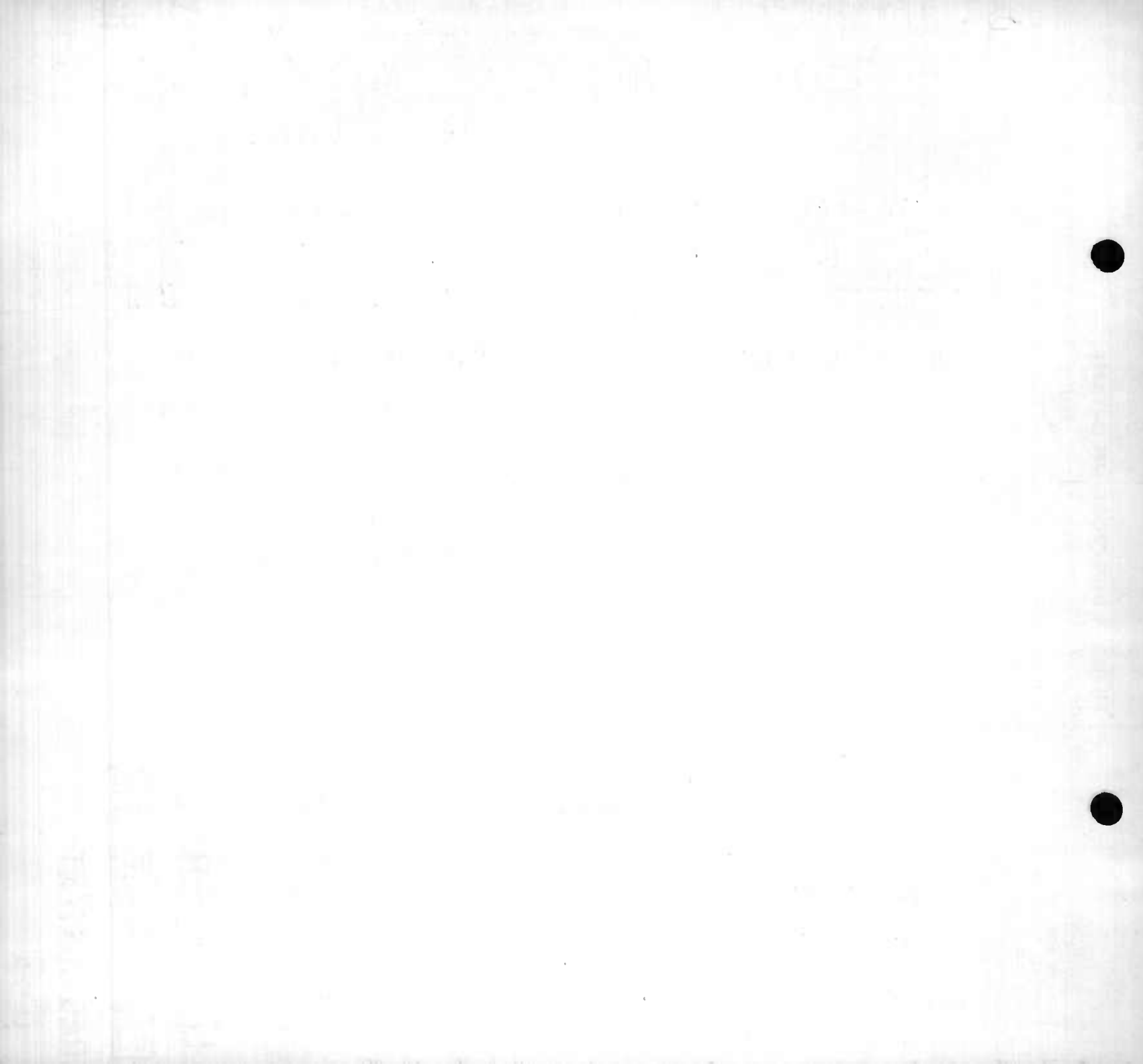
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5229	
BIRTH NO. 67 5229		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JOHANNA D. MASKELL		2. DATE AND HOUR OF DEATH May 25, 1967 4:10 p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3133 Clifftmont Ave. Baltimore, Md., 21213		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 8-01 D. STREET ADDRESS (If rural, give location) 3133 Clifftmont Ave.			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 8/8/1885	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Jansen			
14. MOTHER'S MAIDEN NAME Ellen Humphrey		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 214-01-4080B			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Alexander Maskell, husband, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 334X I Cerebral Atherosclerosis Anterior, posterior, generalized		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia, Hypostatic				3 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 25 1967 to May 25 1967, that (I) (we) last saw the deceased alive on May 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin F. Polek		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED May 29, 1967	
23C. PHYSICIAN'S NAME (Type) Dr. Melvin F. Polek		23D. ADDRESS M.D. 3603 Belair Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			
25B. NAME OF REGISTRAR Robert E. Tarkenton		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED No.	
BIRTH NO. 67 5230		CERTIFICATE OF DEATH		67 5230	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CROOKS MARY C.		2. DATE AND HOUR OF DEATH MAY 27 - 67 11:25 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD B. COUNTY BALTIMORE Co.			
NORTH CHARLES GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
D. STREET ADDRESS (If rural, give location)		4247 NECKER AVE #36			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 9-2-77	9. AGE (In years lost in days) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Md Baltimore	
13. FATHER'S NAME ALFRED CROOKS		14. MOTHER'S MAIDEN NAME DELILAH JESSUP		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-54-2153		17. INFORMANT ADDRESS Mrs William Diggins 4247 Necker Avenue	
18. 17 IX I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 9	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) ADENOCARCINOMA OF ENDOMETRIUM			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) CARCINOMATOSIS			
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-26 19 67 to 5-27 19 67 , that (I) (we) last saw the deceased alive on 5-27-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alfredo Arana				23B. DATE SIGNED 5-27-67	
23C. PHYSICIAN'S NAME (Type) DR. CARLOS ARANAGA				23D. ADDRESS 5428 SINCLAIR LANE 21206 BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-31-1967		Mt. Olive Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 31 1967		Alfredo Arana		Classen Funeral Home 7401 Belair Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5231	
BIRTH NO. 67 5231		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Bertha Baublitz		2. DATE AND HOUR OF DEATH 5-27-67 9 50 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hosp.		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, give rural and give township) BALTO.	
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	
8. DATE OF BIRTH 7-2-80		9. AGE (In years lost birthday) 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Invalid	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME ORRIS TRACEY?	
14. MOTHER'S MAIDEN NAME X ELLEN Bember		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-50-3356J1	
17. INFORMANT sister: Mrs. Anna Bagusin, 5726 Cross Country Blvd		ADDRESS Balto.			
18. 443XIV-029X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Uremia, strokes		1 WK.	
ANTECEDENT CAUSES		(B) DUE TO HASCVD		many yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Hypertension, diabetes		many yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes, Syphilis			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 1966 to 5-27 1967 , that (I) (we) last saw the deceased alive on 5-27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Howard Moses				23B. DATE SIGNED 5-27-67	
23C. PHYSICIAN'S NAME (Type) Howard Moses				23D. ADDRESS MD. Arts Bldg. BALTO 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/29/67		24C. NAME OF CEMETERY or CREMATORY Warren, Maryland Poplar Grove Ch. Cem., Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Stewart & Mowen Co., 108 W. North Av., City	

1
A-425

BIRTH NO. 67 5232		BALTIMORE CITY HEALTH DEPARTMENT		67 5232	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
VERNON ALEXANDER			5-26-67 5:25 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
312 N. PERAL STREET - Amb. Crew #1			Maryland		
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			Baltimore		
D. STREET ADDRESS (If rural, give location)			312 N. Pearl Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Colored	divorced	12-27-1917	49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		none		CHESNEE, S.C.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Jeff alexander			Minnie Lee		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or if yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
unknown				Mr. CLARENCE LANDRUM 2305 Lauretta AVE.	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) Hypertensive and arteriosclerotic cardiovascular disease		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(B) DUE TO		
ANTECEDENT CAUSES			(C)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
RUSSELL S. FISHER, M.D.			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23D. LOCATION (City, town, or county) (State)	
BURIAL		6-2-67		BROOKLYN CHURCH CHESNEE, S.C.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
MAY 31 1967		RUSSELL S. FISHER		MORTON & DYETT FUN'L HOME 1701 LAURENS ST. BALD	

104-52-54

Remains of

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

104-52-54

1
D-120 67 5233

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5233

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

May 29, 1967

12:55 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37
99
MERCY HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Virginia

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Buena Vista

D. STREET ADDRESS (If rural, give location)

2317 Maple Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Dec. 5, 1891

9. AGE (In years
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Entertainer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Amherst Co. Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John E. Davis

14. MOTHER'S MAIDEN NAME

Massie Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Amole Funeral Home Buena Vista, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/29/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-2-67

23C. NAME of CEMETERY or CREMATORY

Green Hill Cemetery

23D. LOCATION (City, town, or county)

Buena Vista

(State)

Va.

24A. DATE REC'D BY HEALTH DEPT.

MAY 31 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc.

1217 St. Paul St.

10-10-10

10-10-10

10-10-10

10-10-10

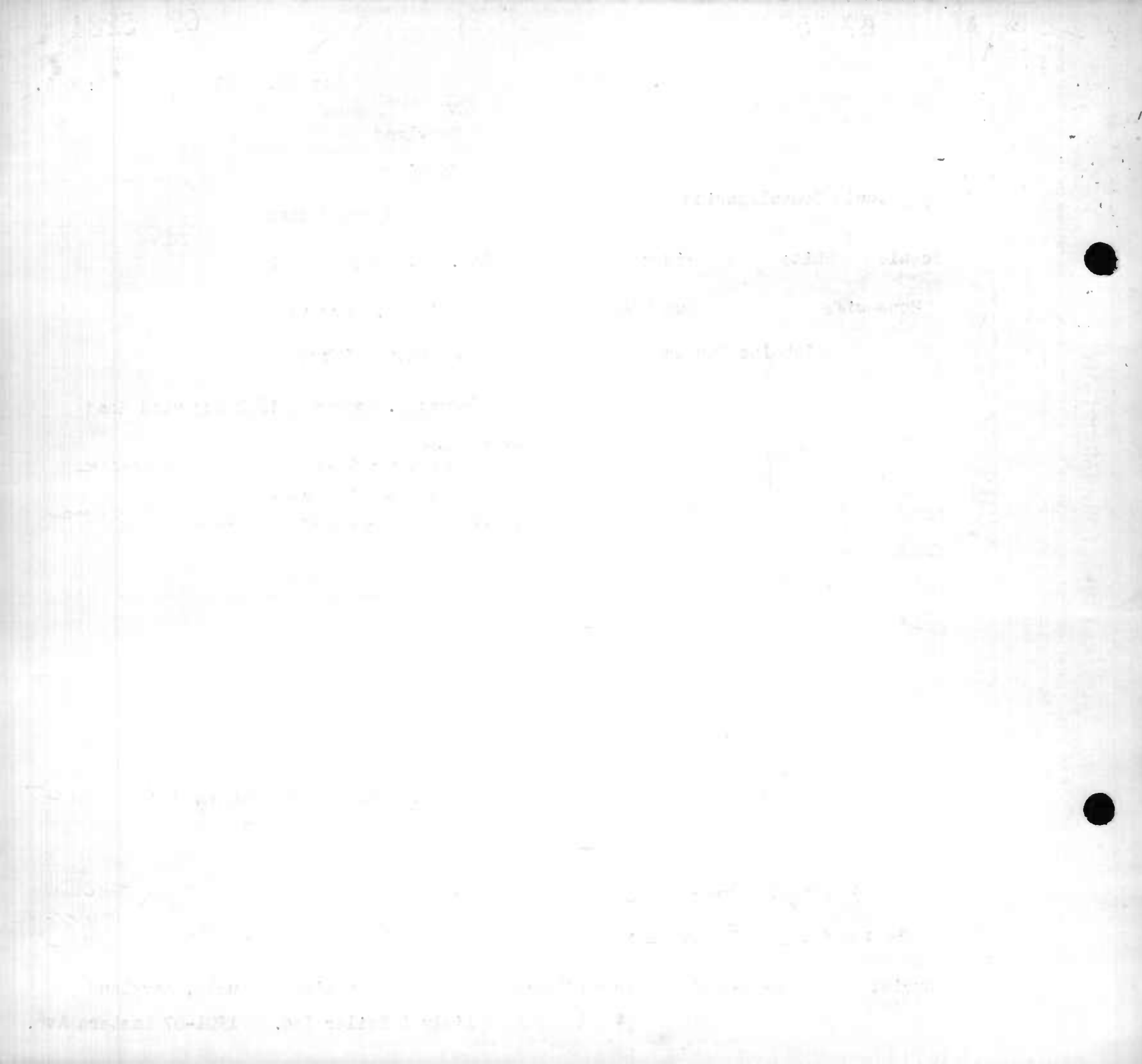
10-10-10

10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5234	
BIRTH NO. 67 5234		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CLARA H. WAYSON		2. DATE AND HOUR OF DEATH May 28, 1967 9:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium		A. STATE Maryland B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00			
		D. STREET ADDRESS (If rural, give location) 1832 Edgewood Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Jan. 22, 1885	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Nicholas Sebour		14. MOTHER'S MAIDEN NAME Johanna Seifart			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Thomas R. Wayson 1832 Edgewood Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION CAUSING IT CENTRAL Hemorrhage arterio-sclerotic cardio-vascular disease		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years	
19. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 30 1966 to May 28 1967, that (I) (we) last saw the deceased alive on May 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE George Sawyer		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/29/67	
23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER		23D. ADDRESS M.D. 4808 Harford Rd. - Baltimore 14 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-1967		24C. NAME OF CEMETERY or CREMATORY Sacred Heart	
				24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Bess E. Talbot		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

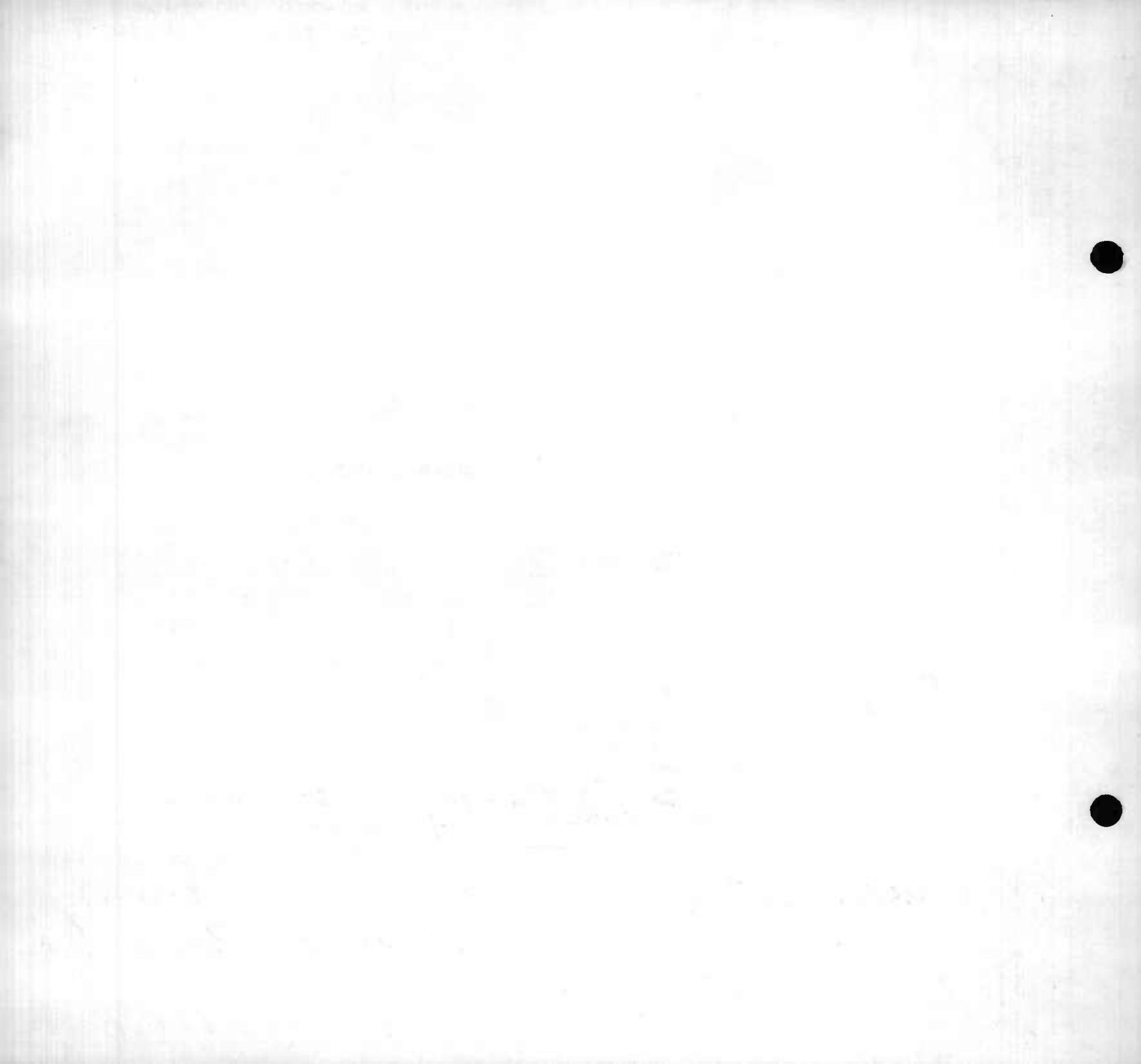
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5235</u>	
BIRTH NO. <u>67 5235</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>STEWART, Carrie</u>		2. DATE AND HOUR OF DEATH <u>5/26/67</u> <u>4:10</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lincoln Memorial Nursing Home</u> <u>27 N. CAREY ST.</u> <u>Baltimore, Md. 21223</u>		A. STATE <u>Md</u> B. COUNTY <u>22-01</u>			
5. SEX <u>FEMALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
8. DATE OF BIRTH <u>2/12/1890</u>		9. AGE (In years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unk.</u>	
14. MOTHER'S MAIDEN NAME <u>Susie Ann William</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Louise Ford</u>		ADDRESS <u>129 W. Lee St</u>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cerebral Thrombosis</u>	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-19-1967</u> to <u>5-26-1967</u> that (I) (we) lost saw the deceased alive on <u>5-26-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D.				23B. DATE SIGNED <u>5/26/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>HARRIS DEWARINE</u> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5/31/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Brooklyn Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 31 1967</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>661 W. Barre St</u>	

James Thompson
June 1st

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5236</u>	
BIRTH NO. <u>67 5236</u>				M.	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Richards, William</u>			2. DATE AND HOUR OF DEATH <u>May 27, 1967</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital Inc.</u> <u>1514 Divvsnon Street</u> <u>Baltimore, Maryland 3 21216</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1606</u>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			D. STREET ADDRESS (If rural, give location) <u>3006 Raynor Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>4-11-13</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Sugar Refining Co.</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Unk.</u>		
14. MOTHER'S MAIDEN NAME <u>Unk.</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Records</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA</u> <u>CARCINOMA OF STOMACH</u> <u>POST OPERATIVE TOTAL GASTRECTOMY</u> <u>CARCINOMA OF STOMACH</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>5-18-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA OF STOMACH</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-8-</u> <u>1967</u> to <u>5-27-</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>5-27-</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>E. C. CLAY</u>				23B. DATE SIGNED <u>5-27-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. C. CLAY</u>				23D. ADDRESS <u>3405 GARRISON BLVD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/3/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus New PK</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 31 1967</u>			
25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u>			
25D. ADDRESS <u>661 W. [unclear]</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5238	
BIRTH NO. 67 5238		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) THOMAS FULLER		2. DATE AND HOUR OF DEATH 5-29-67 10¹⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND. B. COUNTY 28-02			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI Hosp. of BALTO.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 2708 OAKHILL AVE #7.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER	8. DATE OF BIRTH 4-10-88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER.		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME unk.		14. MOTHER'S MAIDEN NAME unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO.		17. INFORMANT 2908 Oakhill Ave.	
18. 733.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) ASPIRATION PNEUMONIA DUE TO		1 hour.	
ANTECEDENT CAUSES		(B) CVA DUE TO		3 weeks.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) ASCVD.			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
		ATRIAL FIBRILLATION			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-10-1967 to 5-29-1967 , that (I) (we) last saw the deceased alive on 5-29-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leslie Abramowitz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 5-29-67		
23C. PHYSICIAN'S NAME (Type) Leslie Abramowitz		M.D.	23D. ADDRESS SINAI HOSP. OF BALTO.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/1/67	24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Charles E. Farley		25C. FUNERAL DIRECTOR Charles A Rice 661 W 13th St	

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

1000 1000

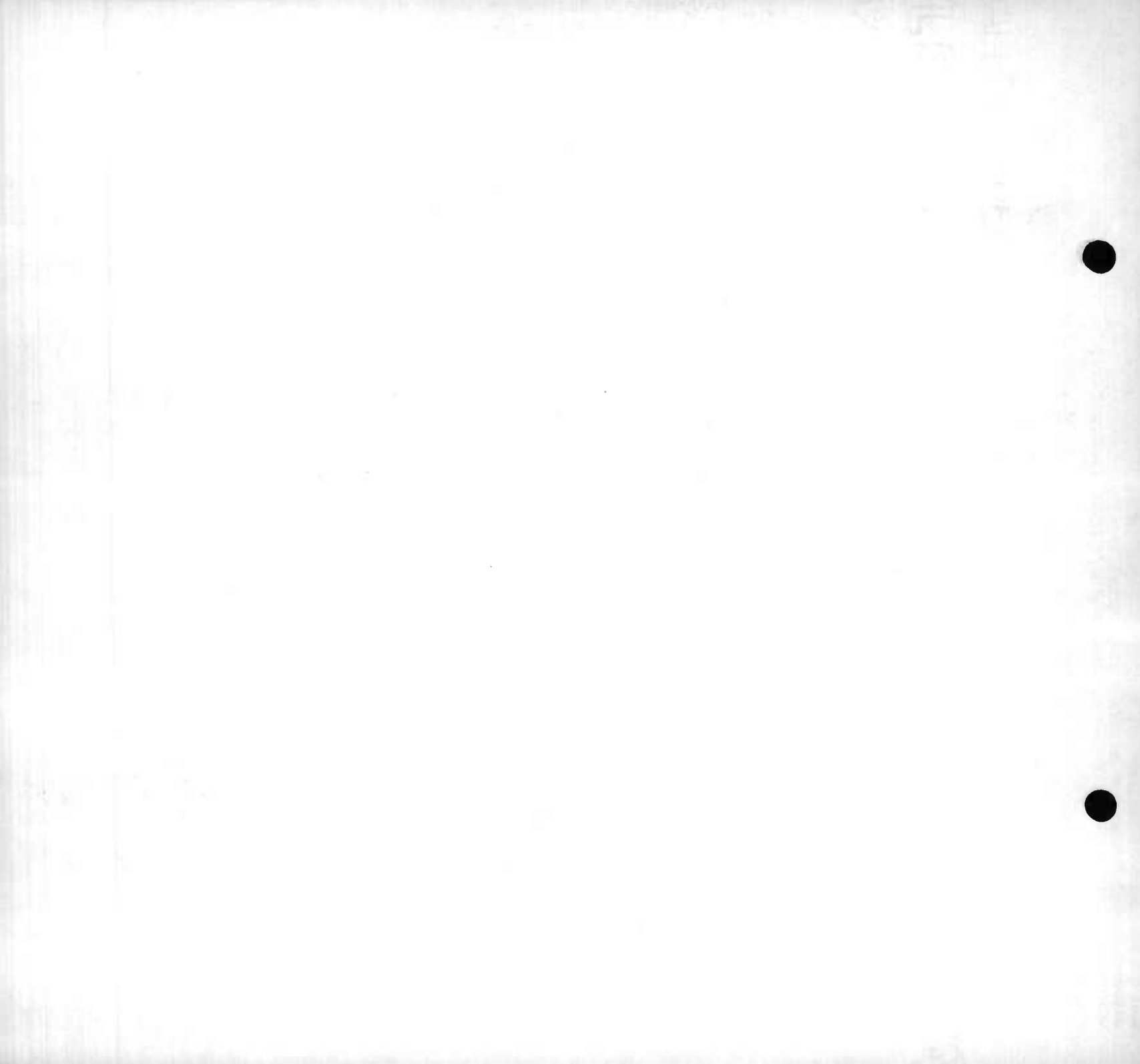
1000 1000

1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5239		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 837 5239	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>BATEMAN, Walter</i>		2. DATE AND HOUR OF DEATH <i>5/30/67</i> <i>15³²</i> <i>A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>15-11</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bolton Hill Nursing & Convalescent Center</i>		D. STREET ADDRESS (If rural, give location) <i>3778 Columbus Drive</i>			
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>6-15-1900</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>freeman</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>unk.</i>		14. MOTHER'S MAIDEN NAME <i>unk.</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>231-03-4511</i>		17. INFORMANT ADDRESS <i>Jane Lyles 3778 Columbus Dr.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Congestive Heart Failure</i> DUE TO (B) <i>arteriosclerotic heart disease</i> DUE TO (C) <i>Pericardial failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>5 years</i> <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/13</i> 19 <i>67</i> to <i>5/30</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5/30</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>allan H. Macht</i> M.D.				23B. DATE SIGNED <i>5/30/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT</i> M.D.		23D. ADDRESS <i>2 EAST READ ST 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/3/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Wt Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 31 1967</i>			
25B. NAME OF REGISTRAR <i>Charles E. Rice</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Charles E. Rice 661 W. Garrett St</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5240		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5240	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Hele Wortham</i>			2. DATE AND HOUR OF DEATH <i>10³⁵ pm 5/28/67</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hosp</i> 4940 Eastern Ave. Baltimore, Md. #21224			A. STATE <i>Md</i> B. COUNTY <i>8-06</i>		
5. SEX <i>Male</i>			6. RACE <i>Negro</i>		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)			8. DATE OF BIRTH <i>4-15-19</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemploy</i>			11. BIRTHPLACE (State or foreign country) <i>So Caro.</i>		
13. FATHER'S NAME <i>Armenis</i>			14. MOTHER'S MAIDEN NAME <i>Eula Barnett</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT ADDRESS <i>#21224</i> BCH: Records 4940 Eastern Ave. Baltimore, Md.					
18. <i>456X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>hemorrhage</i> DUE TO (B) <i>thrombosis</i> DUE TO (C) <i>generalized vasculitis</i>		
			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>10 days</i> <i>21 days</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>he</i> (this hospital) attended the deceased from <i>5/10</i> 19 <i>67</i> to <i>5/28</i> 19 <i>67</i> , that (I) <i>he</i> last saw the deceased alive on <i>5/25</i> 19 <i>67</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>he</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Monica M. Buckley</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>5/29</i>	
23C. PHYSICIAN'S NAME (Type) <i>Monica M. Buckley</i>				23D. ADDRESS <i>Baltimore City Hospitals</i> M.D. <i>4940 Eastern Ave. Baltimore, Md. # 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/1/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>not Auburn</i>	
24D. LOCATION <i>Baltimore Md.</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 31 1967</i>		25B. NAME OF REGISTRAR <i>R. E. Fairley</i>		25C. FUNERAL DIRECTOR <i>Charles A. Rice</i> ADDRESS <i>66 W. Barre St</i>	

1897

William L. ...

...

...

...

...

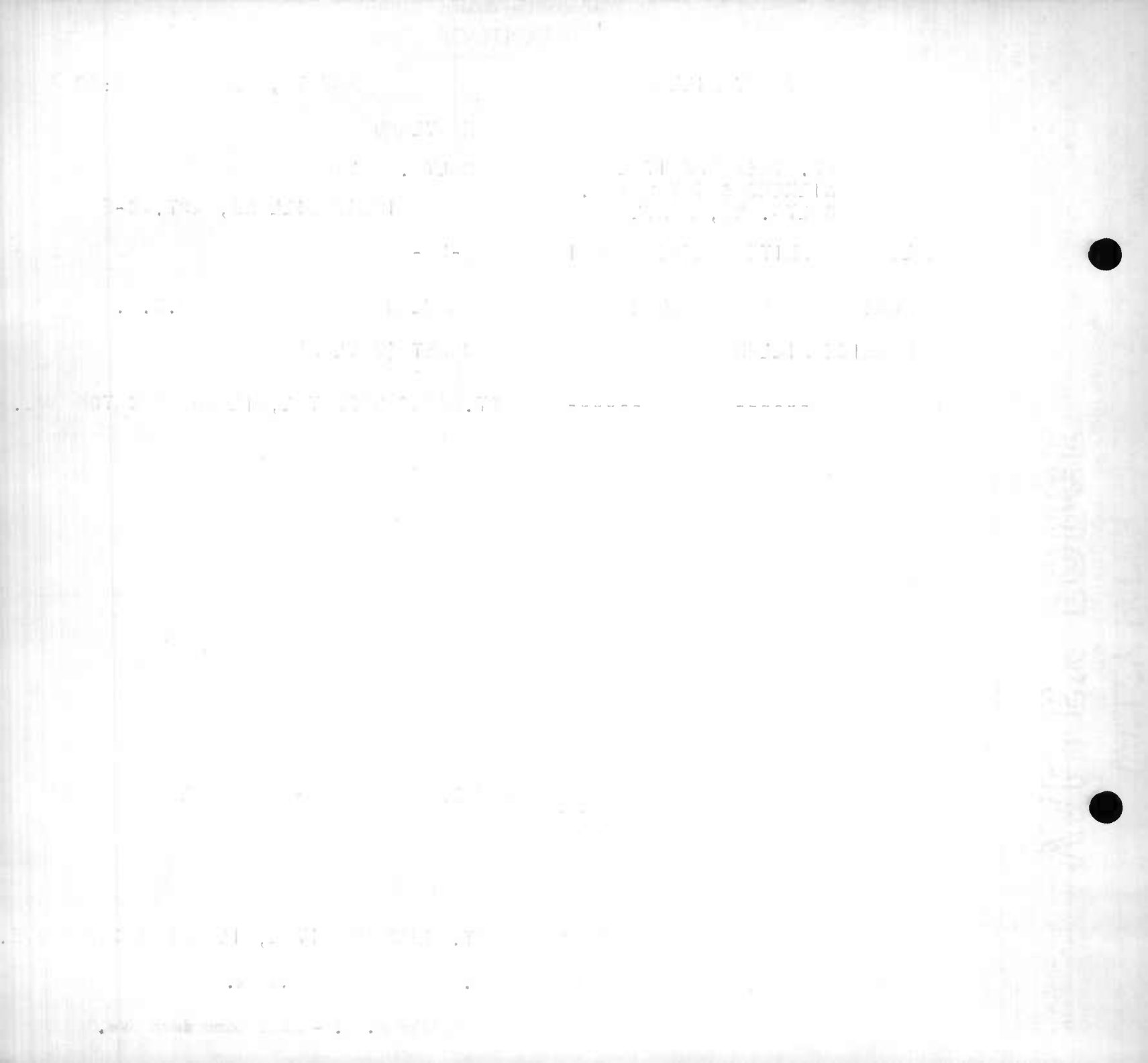
...

...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5241		CERTIFICATE OF DEATH				Registered No. 67 5241			
M.E. CASE NO. 67-10396									
1. NAME OF DECEASED (Type or Print) BABY BOY MILLER						2. DATE AND HOUR OF DEATH MAY 29, 1967 3:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTO. 29, MARYLAND						A. STATE MARYLAND B. COUNTY 28-03			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 21207			
						D. STREET ADDRESS (If rural, give location) 5009 DICKEY HILL RD, APT. C-6			
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED NEVER MARRIED		8. DATE OF BIRTH 5-28-67		9. AGE (In years last birthday) 8 8	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MAURICE MILLER						14. MOTHER'S MAIDEN NAME JANET (TAYLOR)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY						INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from MAY 28 19 67 to MAY 29 1967 , that (I) (we) last saw the deceased alive on MAY 29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Reynaldo O. Guzman M.D.						23B. DATE SIGNED 5/29/67			
23C. PHYSICIAN'S NAME (Type) REYNALDO O. GUZMAN M.D.						23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Edmondson		25C. FUNERAL DIRECTOR Mitzke J. D.		ADDRESS - 4101 Edmondson Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>67 5242</u>				
BIRTH NO. <u>67 5242</u> M.E. CASE NO. <u>67 5242</u> 1. NAME OF DECEASED (Type or Print) MINOR, ROBERT V.					2. DATE AND HOUR OF DEATH MAY 30, 1967 1:15 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTO., MD. 21229					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21229 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5525 CHANNING RD.				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 04-09-01	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT			14. MOTHER'S MAIDEN NAME CATHERINE (MARTIN)			DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212012448		17. INFORMANT Mrs. Isabelle Minor-5525 Channing Rd.-21229 ST. AGNES RECORDS - BALTO., MD. 21229				
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Ante-natal infection ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH Ante-natal infection INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 29, 1967 to MAY 30, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 30, 1967 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Korbuly					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) C. KORBULY,					23D. ADDRESS M.D. WILKENS & CATON AVES ST. AGNES HOSPITAL-BALTO., MD. 21229				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/1/67		24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Witzke P. D.		25C. FUNERAL DIRECTOR ADDRESS 4101 Edmondson Ave.					

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

B-650 67 5243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5243

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RENA G. BROWN

2. DATE AND HOUR PRONOUNCED DEAD

May 25, 1967

12:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1007 Brantley Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1007 Brantley Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan 30 - 1902

9. AGE (in years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

Balto - Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Hanklin

14. MOTHER'S MAIDEN NAME

Julia Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Walter Brown

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

6

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 25, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

5-29-67

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cmt

23D. LOCATION (City, town, or county) (State)

Balto Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SAB-47-97-75

R-200 67 5244

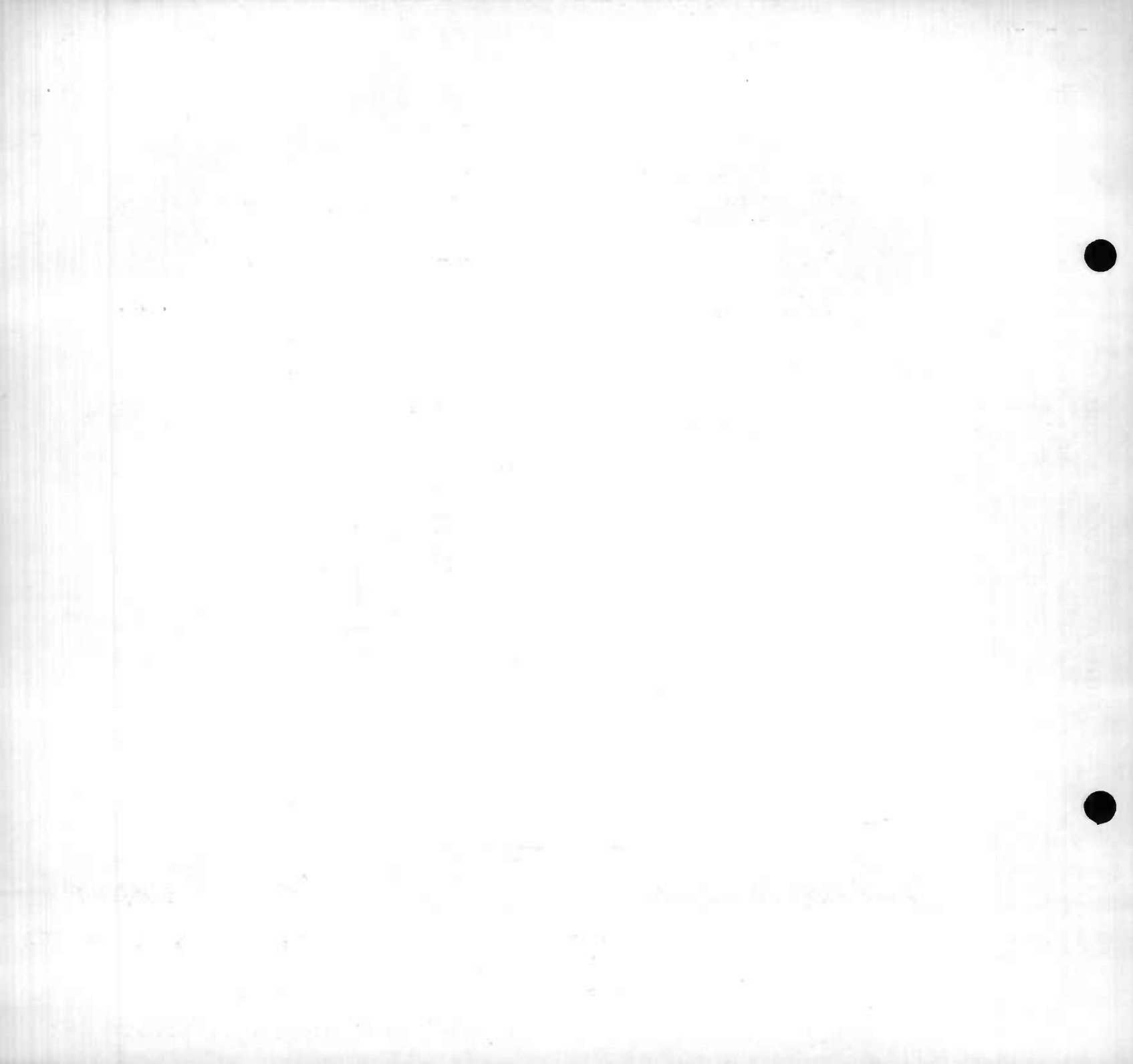
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5244

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 200 67 5244		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Beatrice Rose		2. DATE AND HOUR OF DEATH 5/25/67 8:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, with RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 915 North Durham Street 21205	
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 8-2-1909
9. AGE (In years last birthday) 57		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Smith		14. MOTHER'S MAIDEN NAME Cora Banks	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: BCH-4940 Eastern Avenue 21224		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction with ? DUE TO acute extension ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. diabetes with HASCVD DUE TO Congenital Syphilis		INTERVAL BETWEEN ONSET AND DEATH 2wks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/11 1967 to 5/25 1967, that (I) (we) last saw the deceased alive on 5/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Richard Maffezzoli		23B. DATE SIGNED 5/25/1967	
23C. PHYSICIAN'S NAME (Type) Richard Maffezzoli		23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-29-67	
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Albert E. Jenkins	
25C. FUNERAL DIRECTOR Theodore Wilson		ADDRESS Baltimore Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>67 5245</u>	
BIRTH NO. <u>67 5245</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Jones Florence</u>		2. DATE AND HOUR OF DEATH <u>5/25-1967</u> <u>9⁴⁵ pm</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS</u> <u>34</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>20-02</u>			
				D. STREET ADDRESS (If rural, give location) <u>2124 W. SARATOGA ST.</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED</u> (specify)		8. DATE OF BIRTH <u>3-8-1882</u>	9. AGE (In years, last birthday) <u>85</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Dewey</u>				14. MOTHER'S MAIDEN NAME <u>Lark Hardy</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Florence Jones</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>7-22-11</u> <u>Anterior wall M.I.</u> <u>cardiovascular disease</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-24</u> 19 <u>67</u> to <u>5-25</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-25</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jung Kook Lee</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-25-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jung Kook LEE</u> M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-29-67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>McCarhey Cmt</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn</u> <u>Nel</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 31 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Elmer Wilson or Brantly</u>			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 5246	
BIRTH NO. 67 5246		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		LINTON MCINTOSH		2. DATE AND HOUR OF DEATH 5-27-67 6:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND, B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) EDMONDSON AVENUE 20-02 D. STREET ADDRESS (If rural, give location) 2723 EDMONSON AVE.			
5. SEX MALE	6. RACE NEGROID	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 2-14-14	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Factory		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY MC INTOSH		14. MOTHER'S MAIDEN NAME LULA MURDOCK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 251-24-227		17. INFORMANT Clifton McIntosh ADDRESS	
18. 433.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CONGESTIVE HEART FAILURE DUE TO And CARDIAC ARRHYTHMIA (B) DUE TO MYOCARDIAL DISEASE (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		PROBABLE PNEUMONIA			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from MAY 27 19 67 to MAY 27 19 67, that (X) (we) last saw the deceased alive on MAY 27 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (dXXXX) view the body after death.					
23A. SIGNATURE Murray A. Katz M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) MURRAY A. KATZ M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-67		24C. NAME OF CEMETERY or CREMATORY Cathart	
24D. LOCATION Cathart		24E. LOCATION Cathart		24F. LOCATION Cathart	
25A. DATE RECEIVED BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Gray		25C. FUNERAL DIRECTOR Gray	
25D. ADDRESS Gray		25E. ADDRESS Gray		25F. ADDRESS Gray	

CONFIDENTIAL

SECRET

THE FOLLOWING INFORMATION IS UNCLASSIFIED

DATE 10/10/00

BY SP-5 JAC/BJA

REASON FOR DECLASSIFICATION

1.5X 1.5X 1.5X

EXEMPT FROM AUTOMATIC DECLASSIFICATION

EXEMPT

DATE 10/10/00

BY SP-5 JAC/BJA

EXEMPT FROM AUTOMATIC DECLASSIFICATION

1.5X 1.5X

1.5X 1.5X

1.5X 1.5X

1.5X 1.5X

1.5X 1.5X

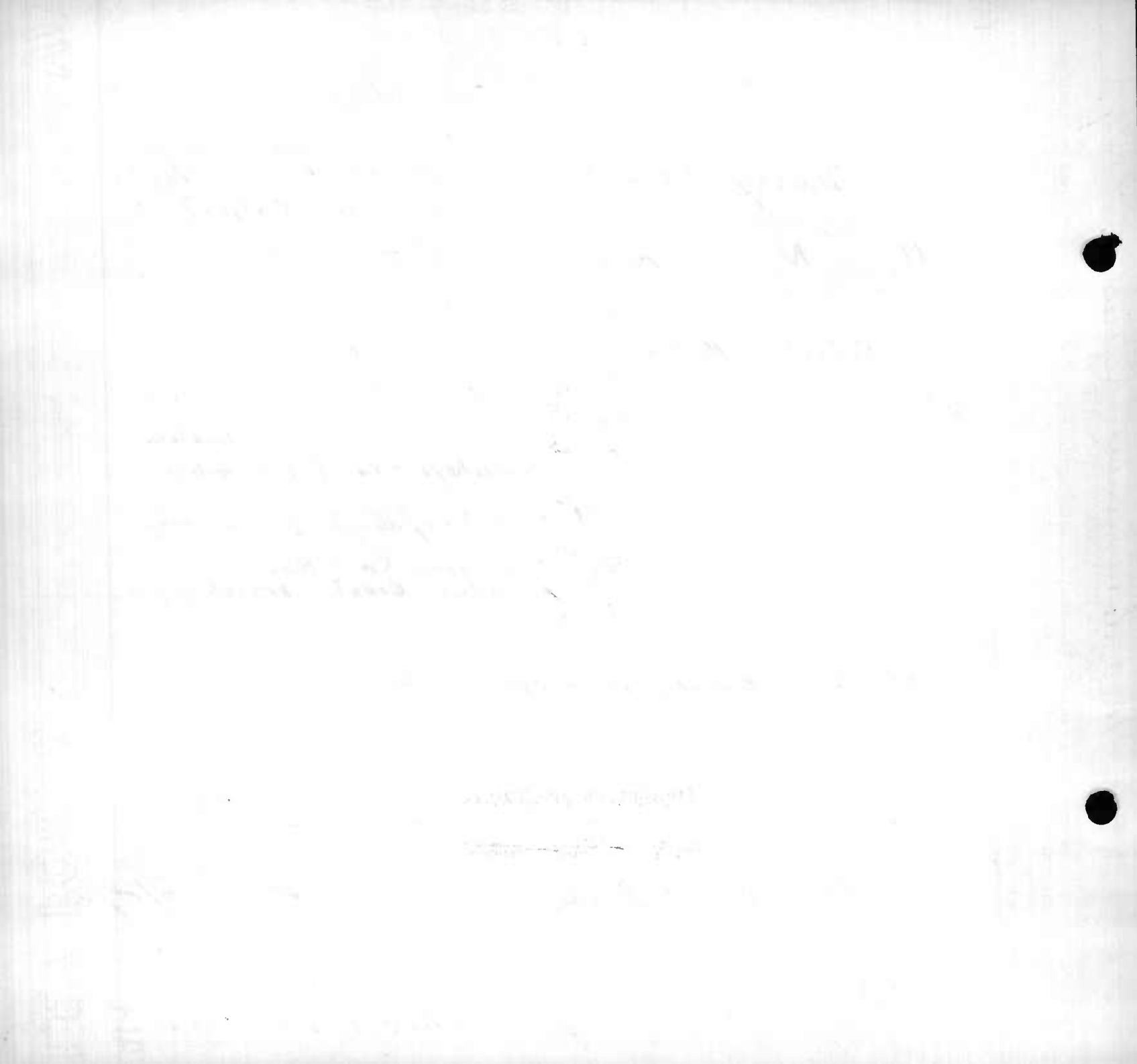
X

EXEMPT FROM AUTOMATIC DECLASSIFICATION

DATE 10/10/00

m-261
 Med. Examiner Released
 FUNERAL DIRECTOR: IMPORTANT
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				67 5247	
BIRTH NO.				67 5247	
M.E. CASE NO.				67 5247	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
M ^C Corkle, Mr. Mack				May 29 1967 1:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
37 Mercy Hospital				MD 12-04	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALTIMORE 21218	
D. STREET ADDRESS (If rural, give location)				2301 No. Calvert ST.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days
M	N	MARRIED	8/9/07	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				South Carolina	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Robert McCorkle			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					Gladys McCorkle 2301 N. Calvert St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease injury or complication which caused death.)			CAUSE OF DEATH		
162.1 I			Superior Vena Cava		
ANTECEDENT CAUSES			(A) Hemorrhage - Via B. pulmonary artery		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Thoracotomy/attempted pneumonectomy		
II			(C) Bronchogenic CA - RULC		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT.			Amputation GREAT VESSELS		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
5/29/67		Bronchogenic CA - RULC		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from May 3 1967 to May 29 1967, that (H) (we) last saw the deceased alive on May 29 1967 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Wm. Gregory Bruce M.D.				5/29/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		6/3/67		Mt. Auburn Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 31 1967		Robert E. Taylor		Wm. E. March 928 E. North Ave	



W-325

67 5248

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 5248

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)JOSEPH ⁷ WATKINS

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

8:55 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3142 Baker Street 21216

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Dec. 23/1929

9. AGE (in years
lost birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Carroll Watkins

14. MOTHER'S MAIDEN NAME

Josephine Dunall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

214-30-4914

17. INFORMANT

ADDRESS

Mary Watkins 3142 Baker St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Craniocerebral injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

3142 Baker Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 12 '67 ?

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Presumable fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-27-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/31/67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Fr. Baltimore

23D. LOCATION

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 31 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Orlinton Phillips 172 N. Mount

ADDRESS

RECEIVED IN CHARGE

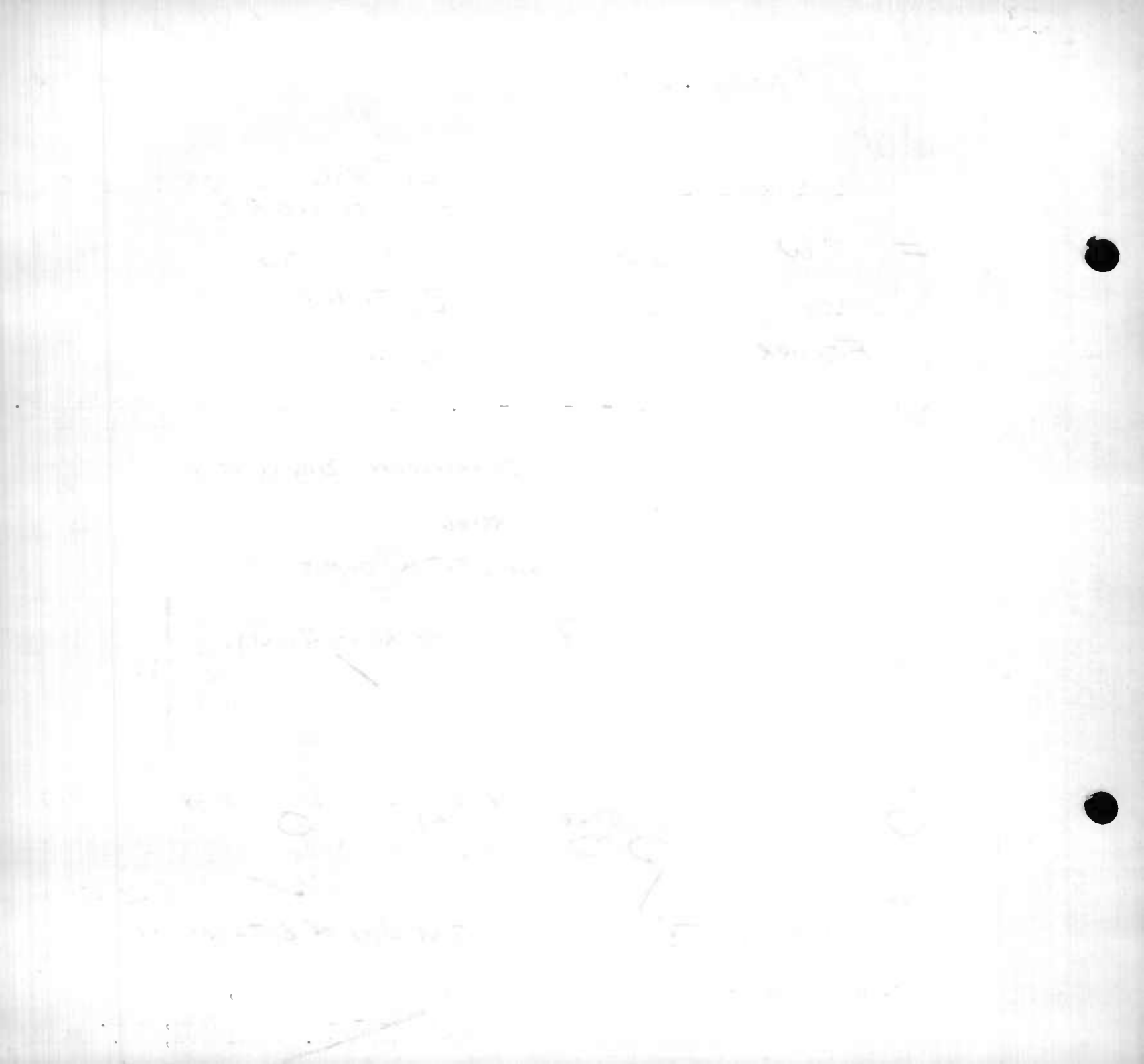
WILLIAM H. BROWN

1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5249	
BIRTH NO. 67 5249		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BARBARA A. BAER		2. DATE AND HOUR OF DEATH 5-28-67 7:34 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-18 D. STREET ADDRESS (If rural, give location) 3535 HAYWARD AVE			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 12-8-87	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
13. FATHER'S NAME Henry Fischer		14. MOTHER'S MAIDEN NAME Emma Hanna			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-10-6641		17. INFORMANT ADDRESS Drs. Thelma Harrison 5316 Overhill Rd.	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) INTRACEREBRAL BLEEDING EPISODE		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO ASCVD. MALNUTRITION, SEPSIS		INTERVAL BETWEEN ONSET AND DEATH	
18. II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PERIPHERAL VASCULAR INSUFFICIENCY.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-26 19 67 to 5-28 19 67 , that (I) (we) last saw the deceased alive on 5-28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leslie Abramowitz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-28-67	
23C. PHYSICIAN'S NAME (Type) Leslie Abramowitz		23D. ADDRESS M.D. SINAI HOSP. OF BALTIMORE, INC.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5-31-67	24C. NAME OF CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212	



BIRTH NO. 67 5250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5250

M.E. CASE NO. 60-15532

1. NAME OF DECEASED (Type or Print) GOLFORD WHITE 2. DATE AND HOUR PRONOUNCED DEAD May 25, 1967 5:58 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, with RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2629 Greenmont Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single

8. DATE OF BIRTH

June 5, 1960

9. AGE (In years last birthday)

6

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Galford

White

14. MOTHER'S MAIDEN NAME

Glenogene

Farinash

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Glenogene Plaughter same address

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia by bolus of food (celery) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia complicating aspiration of small plastic cap.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2629 Greenmont Avenue

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Minute) 5-25-67 4:50 P. M.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Recently aspirated small plastic cap; terminally asphyxiated by celery.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 26, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

5/29/1967

23C. NAME of CEMETERY or CREMATORY

Mt. Olivet Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 31 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Wm. H. Johnson

ADDRESS

Baltimore, Md.

ALLEN B. BOHANN

W. L. CAMPBELL

W. L. CAMPBELL

W. L. CAMPBELL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5251	
BIRTH NO. 67 5251				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) James W. Nolan			2. DATE AND HOUR OF DEATH May 30, 1967 11⁴⁵ A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Baltimore 2303 Pentland Drive C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto D. STREET ADDRESS (If rural, give location) 2303 Pentland Drive		
5. SEX m	6. RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2-28-05	9. AGE (In years lost birthday) 62	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Publishing officer C&O.R.R.			11. BIRTHPLACE (State or foreign country) Va.		
13. FATHER'S NAME Frederick B. Nolan			14. MOTHER'S MAIDEN NAME Emily Batkins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 718 16 9259		
17. INFORMANT Ethel H. Nolan			ADDRESS 2303 Pentland Dr.		
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO 5 hrs INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 5-30-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-30-67 to 5-30-67 , that (I) (we) last saw the deceased alive on 5-30-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William P. Benson, Jr. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5-30-67	
23C. PHYSICIAN'S NAME (Type) WILLIAM P. BENSON, JR. M.D.				23D. ADDRESS 3506 N. CALVERT ST., BALTIMORE, MD	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 5/30/67		24C. NAME of CEMETERY or CREMATORY Greenwood Memorial	
24D. LOCATION (City, town, or county) Richmond Va.		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			
25B. NAME OF REGISTRAR Robert E. Fadden		25C. FUNERAL DIRECTOR Wm J. Fadden			

100-111

100-111

2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5252				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5252	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JACQUELINE H. WALKER				2. DATE AND HOUR OF DEATH 25 May 67 8 AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
THE JOHNS HOPKINS HOSPITAL				OKLAHOMA			
33				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		V-33	
				OKLAHOMA CITY			
				D. STREET ADDRESS (If rural, give location)			
				3209 N W 66 TH STREET			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
FEMALE	WHITE	MARRIED	11-8-42	24			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Ohio			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JOHN HEAGY JR.				MARGARET SMITH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				Johns Hopkins Hospital Records			
18. 75401		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Myocardial Infarction				1 hr.	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		DUE TO					
ANTECEDENT CAUSES		(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Unknown	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
5-24-67		Tetralogy of Fallot		Yes		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from 5-22-67 to 5-25-67, that (we) lost saw the deceased alive on 25 May 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) did not view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
R. A. Marrese				5-25-67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
R. A. Marrese		JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal		5/26/1967				Oklahoma City, Oklahoma	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 31 1967		R. A. Marrese		W. J. Fickman		Baltimore, Md.	

BIRTH NO. 67 5253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5253

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)**HARRY J. CLARK**

2. DATE AND HOUR PRONOUNCED DEAD

May 28, 1967 11:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

200 E. MONTGOMERY STREET4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

200 E. Montgomery Street

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)**Divorced**

8. DATE OF BIRTH

6/30/19109. AGE (In years
last birthday)**56**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Boilermaker**

10B. KIND OF BUSINESS OR INDUSTRY

Steel Mfging.

11. BIRTHPLACE (State or foreign country)

Illinois12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles Francis Clark

14. MOTHER'S MAIDEN NAME

Mary Kelly15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**No****None**16. SOCIAL
SECURITY NO.**216-09-8179**

17. INFORMANT

ADDRESS

Mrs. Frances C. Kossa same address

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Arteriosclerotic Cardiovascular Disease**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)**Werner U. Spitz, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/29/6723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

6/1/1967

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 31 1967

24B. NAME OF REGISTRAR

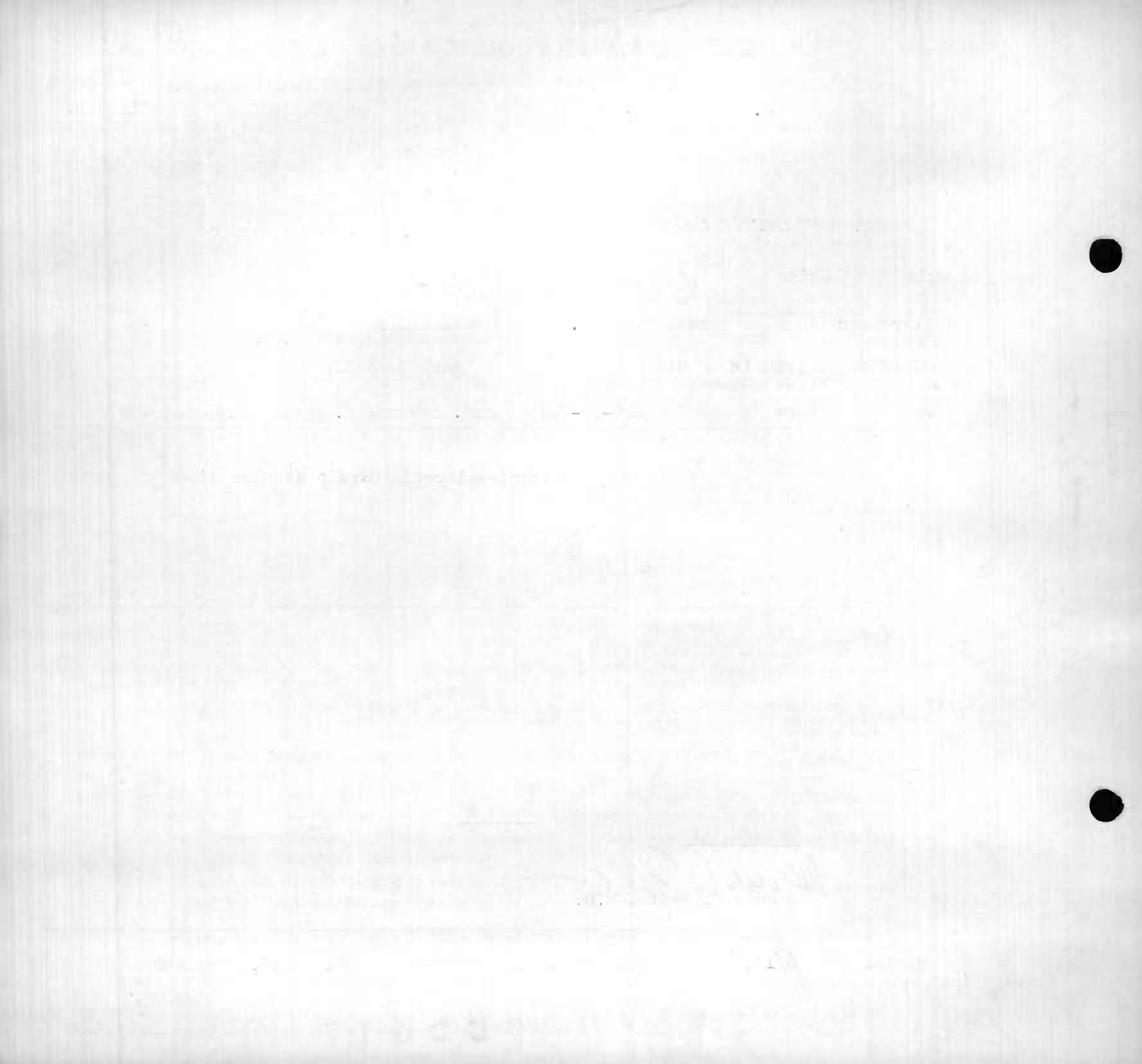
Robert E. Spitz

24C. FUNERAL DIRECTOR

Wm. J. Tinkner & Sons

ADDRESS

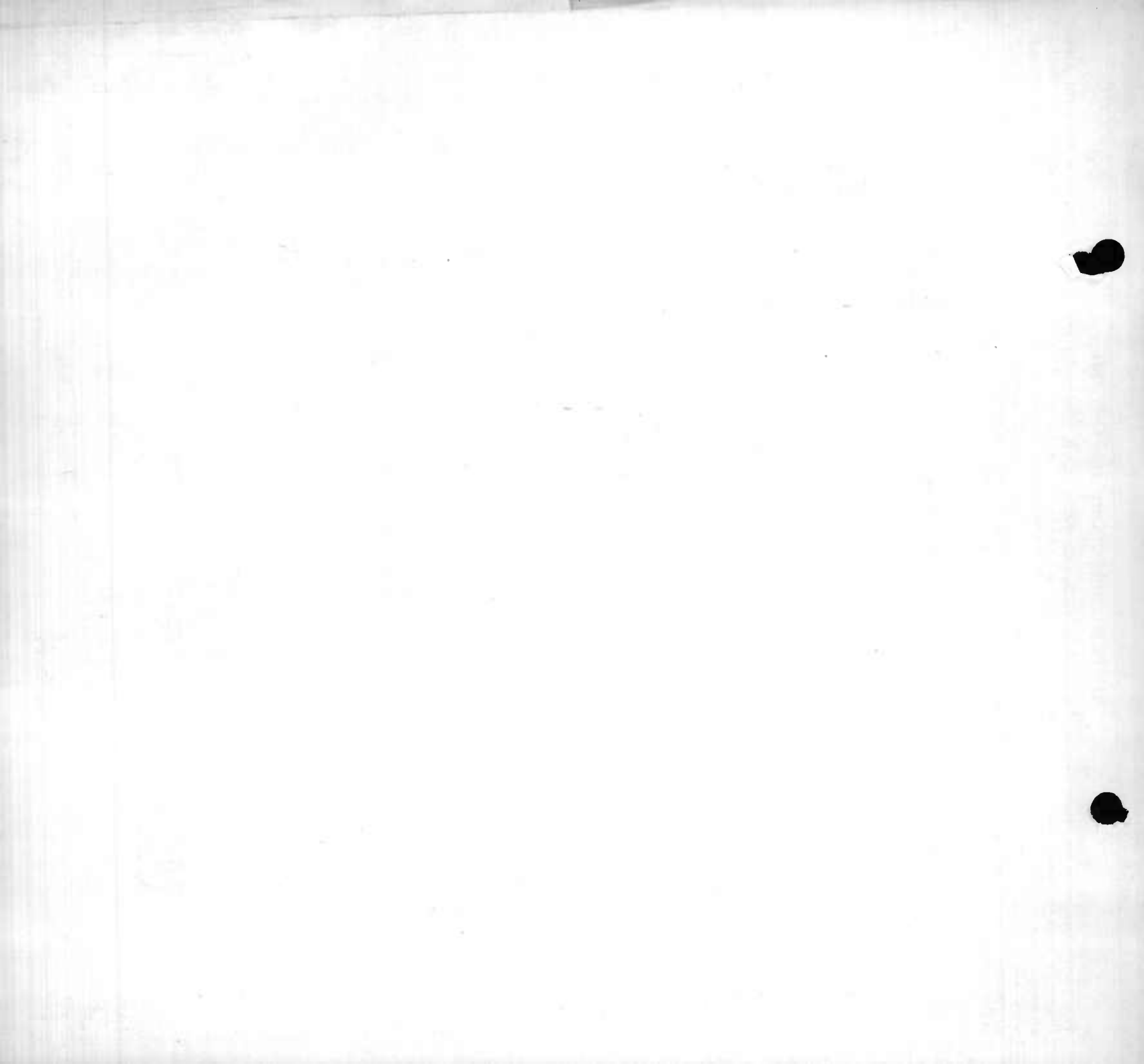
Balt., Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

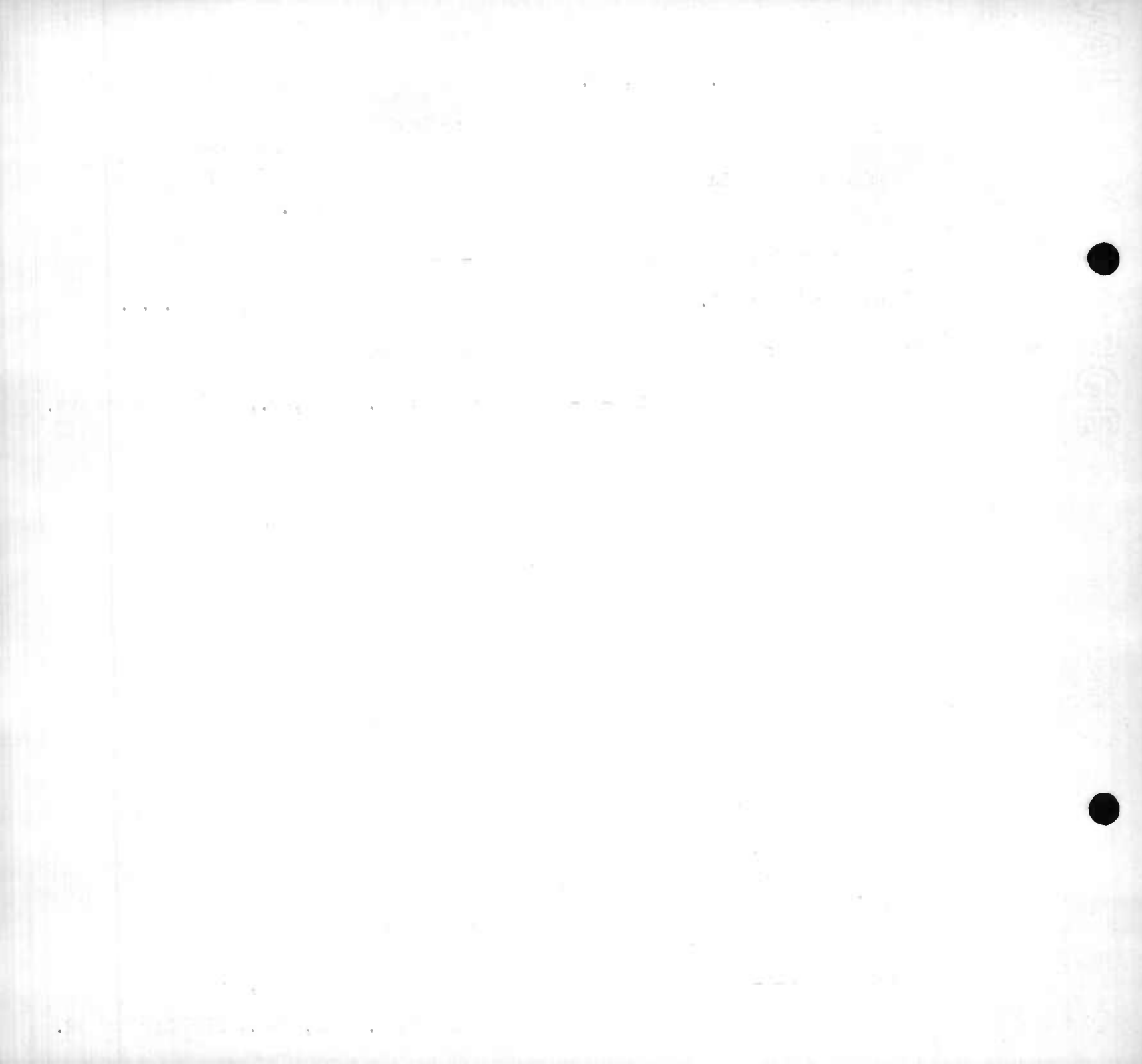
BIRTH NO. 67 5254		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5254	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) STEPHENS, PAUL Backer		2. DATE AND HOUR OF DEATH 5-29-67 11:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL OF BALTIMORE BELVEDERE AT GREENSPRING		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-06		D. STREET ADDRESS (If rural, give location) 11 W. 29th Street	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH Aug. 31, 1901	9. AGE (In years lost birth) 65	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist - Retired		10B. KIND OF BUSINESS OR INDUSTRY B & O RR		11. BIRTHPLACE (State or foreign country) BALTO, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John H. Stephens		14. MOTHER'S MAIDEN NAME Caroline Backer	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 105-05-3427		17. INFORMANT ADDRESS HOSPITAL CHART	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) DUE TO HEPATIC COMA (B) DUE TO CIRRHOSIS OF LIVER (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-7-67 19 to 5-29-67 19 that (I) (we) last saw the deceased alive on 5-29-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. E. VENTURA		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-29-67	
23C. PHYSICIAN'S NAME (Type) L. E. VENTURA		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/1/1967		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. LOCATION (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wm. J. T. ...	
25D. ADDRESS		25E. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5255		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5255	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Frederick G. Gross, Sr.			2. DATE AND HOUR OF DEATH 30 May 1967 3 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesarium			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5404 Hillburn Ave.		
5. SEX M	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-15-88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer Ret.			11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nicholas Gross			14. MOTHER'S MAIDEN NAME Mary Eckert		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-10-1688		17. INFORMANT ADDRESS Frederick G. Gross, Jr., 5404 Hillburn Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Cerebral thrombosis DUE TO (B) Arterio-sclerotic cardiac DUE TO (C) vascular disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 15 April 1967 to 30 May 1967, that (I) (we) last saw the deceased alive on 29 May 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John W. Barnaby			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 30 May 67
23C. PHYSICIAN'S NAME (Type) John W. Barnaby			23D. ADDRESS M.D. 1531 E North Ave		
24A. BURIAL REMOVAL (Specify) Burial	24B. DATE 6-2-67	24C. NAME of CEMETERY or CREMATORY Baltimore		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR B. G. Z. D. B. D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc., 5305 Harford Rd.	



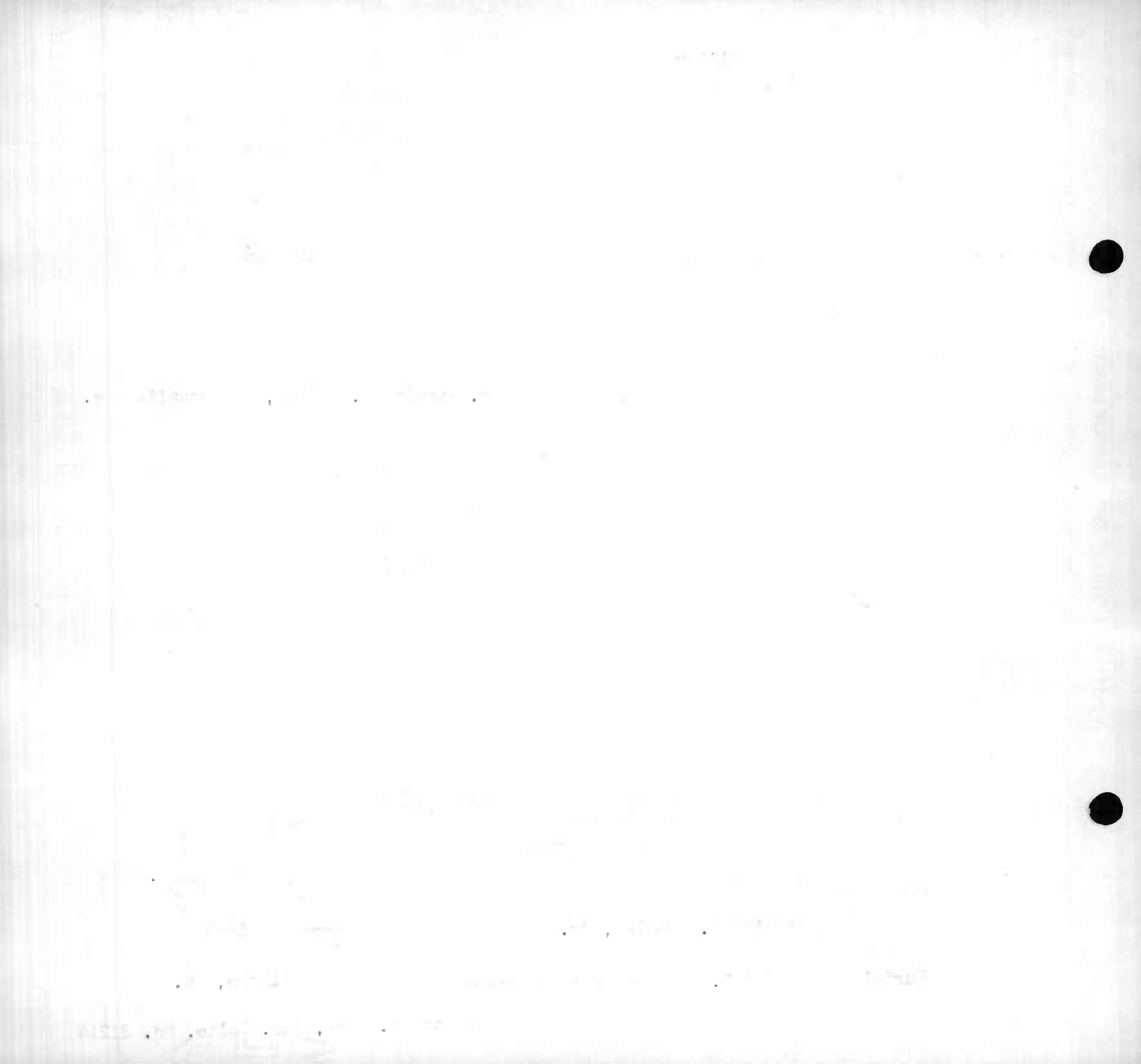
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5256		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5256	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William M. Peach		2. DATE AND HOUR OF DEATH 5/30/1967 7 ¹⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3441 ELMORA AVENUE.			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-19-86	9. AGE (In years last birthday) 79 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME SAMUEL H. PEACH		14. MOTHER'S MAIDEN NAME SOPHIA HINKEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-5702A		17. INFORMANT ADDRESS Ruth T. Peach, 3441 Elmora Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO CVA ASCVD		INTERVAL BETWEEN ONSET AND DEATH 15 days 15 days years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S.W. Spaulding				23B. DATE SIGNED 5/30/67	
23C. PHYSICIAN'S NAME (Type) STEPHEN W. SPAULDING				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-2-67		24C. NAME of CEMETERY or CREMATORY Parkwood	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR ADDRESS Leonard G. Buck, Inc., 5305 Harford Rd.			
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Leonard G. Buck, Inc., 5305 Harford Rd.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPT.				BIRTH NO. 67 5257		REGISTERED NO. 67 5257	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>Miller Rose Marie A. Bew</i>				2. DATE AND HOUR OF DEATH <i>5-30-67 12 00 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital 37</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>11-03</i> D. STREET ADDRESS (If rural, give location) <i>607 N. Eutaw St.</i>			
5. SEX <i>female</i>		6. RACE <i>Caucasian</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>7-28-00</i>	
9. AGE (In years lost birthday) <i>66</i>		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Robert Williams</i>			
14. MOTHER'S MAIDEN NAME <i>Anna Morrison</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>220-03-3625</i>				17. INFORMANT ADDRESS <i>Mr. Stanley R. Miller, 2912 Rosalie Ave. #6</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) <i>intraventricular hemorrhage</i> DUE TO (B) <i>thrombocytopenia</i> DUE TO (C) <i>acute lymphoblastic leukemia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>approx 2hrs</i> ? ?	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>2</i>							
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>11:30 AM 5-24 1967</i> to <i>12 PM 5-30 1967</i> , that (we) last saw the deceased alive on <i>5-30 1967</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Raymond E. Knowles Jr.</i> M.D.				23B. DATE SIGNED <i>5-30-67</i>		23C. PHYSICIAN'S NAME (Type) <i>Raymond E. Knowles, Jr.</i> M.D.	
23D. ADDRESS <i>Mercy Hospital</i>				24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>6/2/67.</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 31 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Gaskins</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
67 5258		CERTIFICATE OF DEATH		67 5258	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		LITTLEPAGE, CARROLL B		MAY 28, 1967 12:15P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
40 ST. AGNES HOSPITAL		MARYLAND		Baltimore	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 21228	
		D. STREET ADDRESS (If rural, give location)		37 NO BELLE GROVE RD.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years)	10. If Under 1 Yr. Months; Days
MALE	WHITE	WIDOWED, DIVORCED (specify)	2-2-82 2/4/83	85 84	
		MARRIED			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		FURNITURE SALESMAN		VIRGINIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
WILLIAM T (DEC'D)		UNKNOWN LOUISE (DEC'D) LIPSCOMB		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NONE		220-05-9028		ST. AGNES HOSPITAL RECORDS 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MAY 27 1967 to MAY 28 1967, that (X) (we) last saw the deceased alive on MAY 28 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
L. Anger Geny					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
GEORGE ANGOV,		ST. AGNES HOSP; CATON & WILKENS AVES.		21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		6 May 31, 67		WESLEY CHAPEL	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
ROCK HALL, MD		MAY 31 1967		Robert E. Sisk	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
				E.S. MACNABB 301 FREDERICK RD 21228	

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

10-11-57

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5259		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5259	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) TOLBERT, LOLA VIRGINIA			2. DATE AND HOUR OF DEATH 5/28 1967 11:55 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4133, BUENA VISTA 21211		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH JAN/26-'09	9. AGE (In years lost birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME IRA LATHAM			14. MOTHER'S MAIDEN NAME EDITH JUSTICE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 212-01-7724	17. INFORMANT CHART		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebrovascular Hemorrhage DUE TO (B) Arterial Hypertension DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 20 hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/27 1967 to 5/28 1967 , that (I) was lost saw the deceased alive on 5/27 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE M. Dr. Peterson				23B. DATE SIGNED 5/28 '67	
23C. PHYSICIAN'S NAME (Type) M. DR. PETERSON		23D. ADDRESS THE UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31-67		24C. NAME OF CEMETERY or CREMATORY Goodshepherd	
24D. LOCATION (City, town, or county) (State) Howard Co. Md					
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Frank J. Seitz	
				ADDRESS 814 136th St.	

1912

MARYLAND

PAID

AT 12.11.12

11/20/12

MARYLAND

EDITED

CHART

General Hospital
Annapolis

UNION MEMORIAL HOSPITAL

MARRIED

HOUSEWIFE

IRATHAM

UNKNOWN

11

2152

2152

M. R. Johnson
M. R. Johnson

UNION MEMORIAL HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>67 5260</u>				
BIRTH NO. <u>67 5260</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>COSGRAVE JOHN</u>					2. DATE AND HOUR OF DEATH <u>10 PM 5/27 1967</u> P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> (If not in hospital or institution, give street address or location)					A. STATE <u>MARYLAND</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>				
					D. STREET ADDRESS (If rural, give location) <u>2835, HUNTINGTON AVE 21211</u>				
5. SEX <u>W</u> M	6. RACE <u>M</u> W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>9/3 '07</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-PAINTER</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM D. COSGRAVE</u>					14. MOTHER'S MAIDEN NAME <u>FRANCES ELIZABETH (UNKN)</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>217-09-4840</u>		17. INFORMANT ADDRESS <u>CHART</u>		
18. CAUSE OF DEATH									
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><u>42011</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>(A) DUE TO <u>ACUTE MYOCARDIAL INFARCTION</u></p> <p>(B) DUE TO <u>ASCVD</u></p> <p>(C) _____</p> </div> <div style="width: 10%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Few hours</u></p> </div> </div>									
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Sept. 1966</u> to <u>April 1967</u> , that (I) <u>(we)</u> lost <u>saw</u> the deceased alive on <u>April 27th 1967</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.									
23A. SIGNATURE <u>M. Petersson</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>5/28 '67</u>	
23C. PHYSICIAN'S NAME (Type) <u>M. PETERSSON</u>					23D. ADDRESS M.D. <u>UNION MEMORIAL HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/31-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 31 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Frank J. Seitz</u>		ADDRESS <u>814 W 36th St</u>			

COOPER

UNION MEMORIAL

W M

HOUSE-PAINTER

WILLIAM D COOPER

Not known

MARYLAND

PLATINUM

5833, HUNTINGTON AVE

PL 107 22

MARYLAND

FRANCIS ELIZABETH

CHART

ACUTE MYOCARDIAL
INFARCTION
A260

No

Apr 25 1963
Apt 107 22

M. Johnson

M. PETERSON

UNION MEMORIAL
2/2/63

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5261	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5261 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) NELSON ANNIE			2. DATE AND HOUR OF DEATH 5.26.1967 7.40 a.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div>A. STATE MD.</div> <div>B. COUNTY 15-02</div> </div>		
5. SEX F.			6. RACE C		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WID.
8. DATE OF BIRTH 2.19.91		9. AGE (In years lost birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Percy Rawlings			14. MOTHER'S MAIDEN NAME Margaret		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mildred Quarrels 1727 Payson St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4-3-81 C.V.A. (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH 7 weeks.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic pyelonephritis.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4.5.67 to 5.26.67 that (I) (we) last saw the deceased alive on 5.25.67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nikola Radotkovic			23B. DATE SIGNED 5.26.67		23C. PHYSICIAN'S NAME (Type) MROS RADOJKOVIC
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 5-31-67		24C. NAME of CEMETERY or CREMATORY Balto. Nat'l. Cem.
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS George A. Allen 1518 N. E. Ave

3-12-1967
1727 PAVSON ST
2-19-7
MD

William Rogers
C
WID

CVA
Hypertension (ASCVD)

Chronic pharyngitis

2 12 4-5 21 2 20

Miss RUTHENIC
James RUTHENIC
+ 200 CT
Hudson High Sch

Miss Ruthenic

BIRTH NO. 67 5262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5262

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BENJAMIN

FAUNTLEROY

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

5:53 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1136 N. Gilmor Street 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

4-25-20

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Abraham Fauntleroy

14. MOTHER'S MAIDEN NAME

Pauline

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

219032673

17. INFORMANT

ADDRESS

Elise Fauntleroy 906 Stricker St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-27-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5-31-67

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

Arbutus, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 31 1967

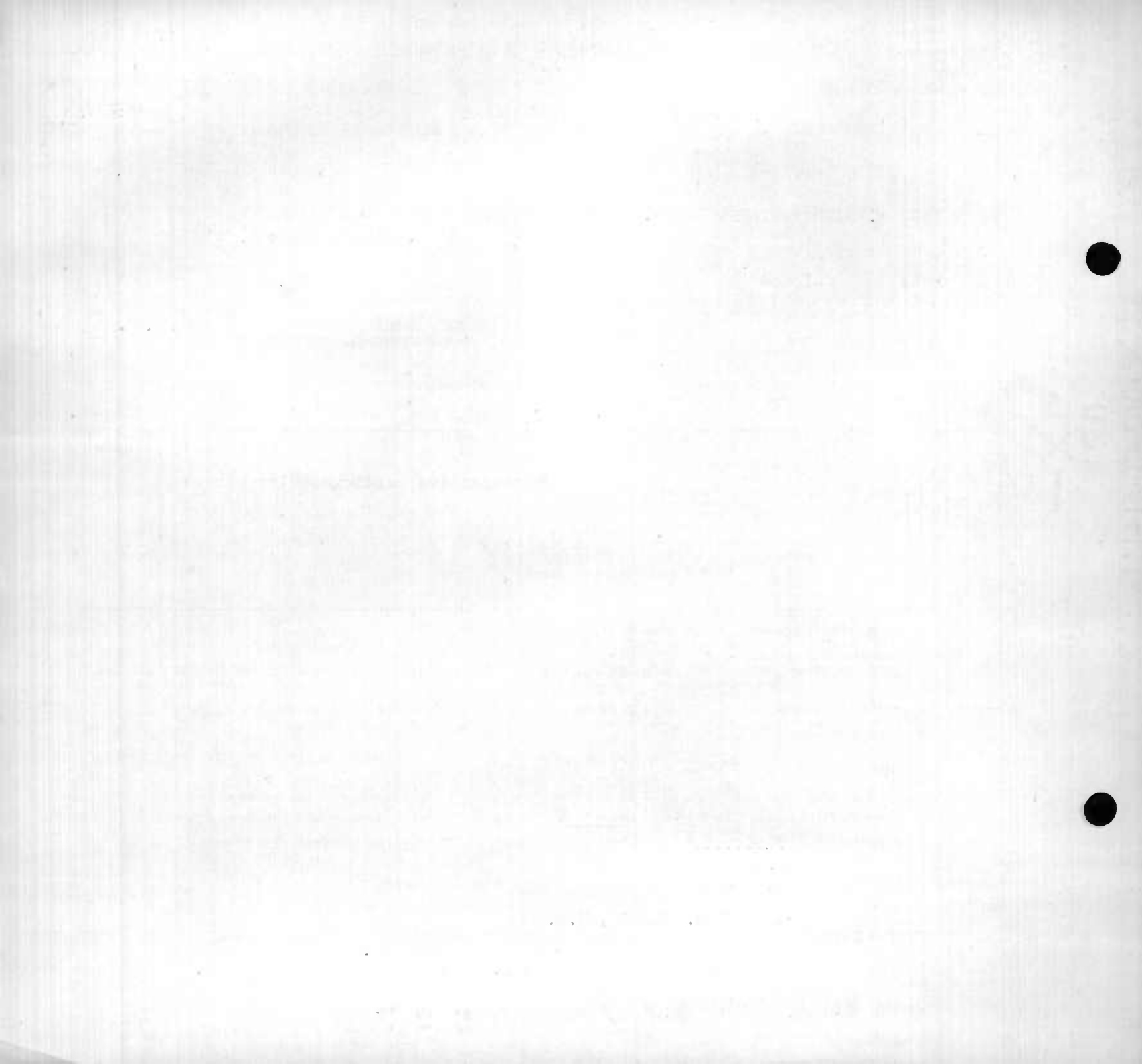
24B. NAME OF REGISTRAR

R. S. Fisher

24C. FUNERAL DIRECTOR

Wilson Funeral Home 1348 Calhoun St.

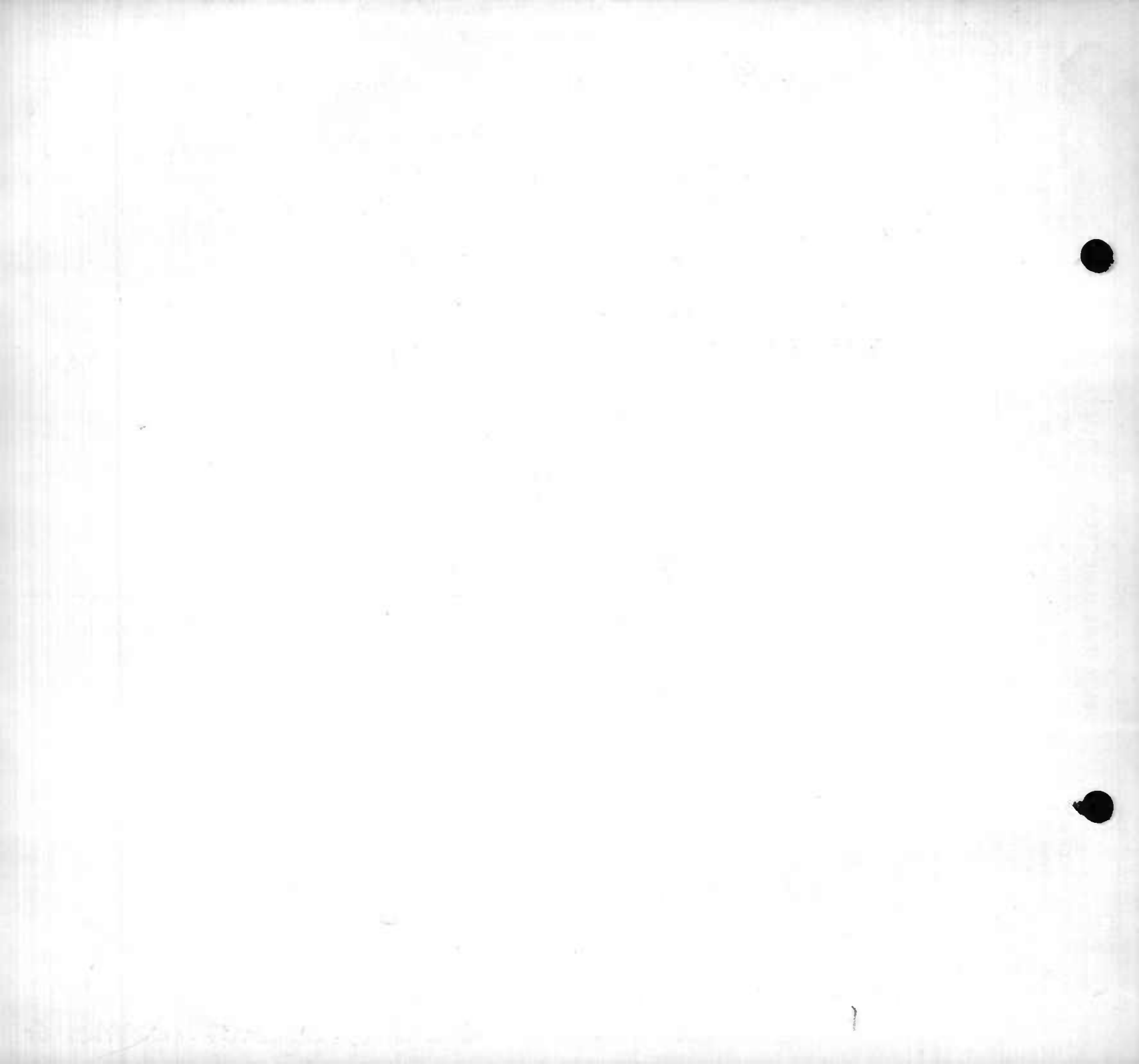
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5263		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5263	
M.E. CASE NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) MARY OLIVIA TATUM		MAY 24 1967		5:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION union memorial Hospital		A. STATE Maryland		B. COUNTY	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN BALTIMORE		(If outside city limits, write RURAL and give township)	
44		D. STREET ADDRESS 2312 Guilford Ave		21218	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-18-10	9. AGE (In years last birthday) 56	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME ROBERT MASON		14. MOTHER'S MAIDEN NAME LOVENIA (UNKNOWN) CHAPMAN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 217-50-2572		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Epidermoid Carcinoma of the cervix uteri, stage IV (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 9-9-66 to 5-24-67, that (I) lost saw the deceased alive on 5-24-67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE AN CHUN CHEN		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) AN CHUN CHEN		23D. ADDRESS union memorial Hospital, 33rd x Guilford Ave, Baltimore, Md 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-27-67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967			
25B. NAME OF REGISTRAR R. B. E. Taylor		25C. FUNERAL DIRECTOR R. B. E. Taylor			
25D. ADDRESS 2431 E. Oliver St.					

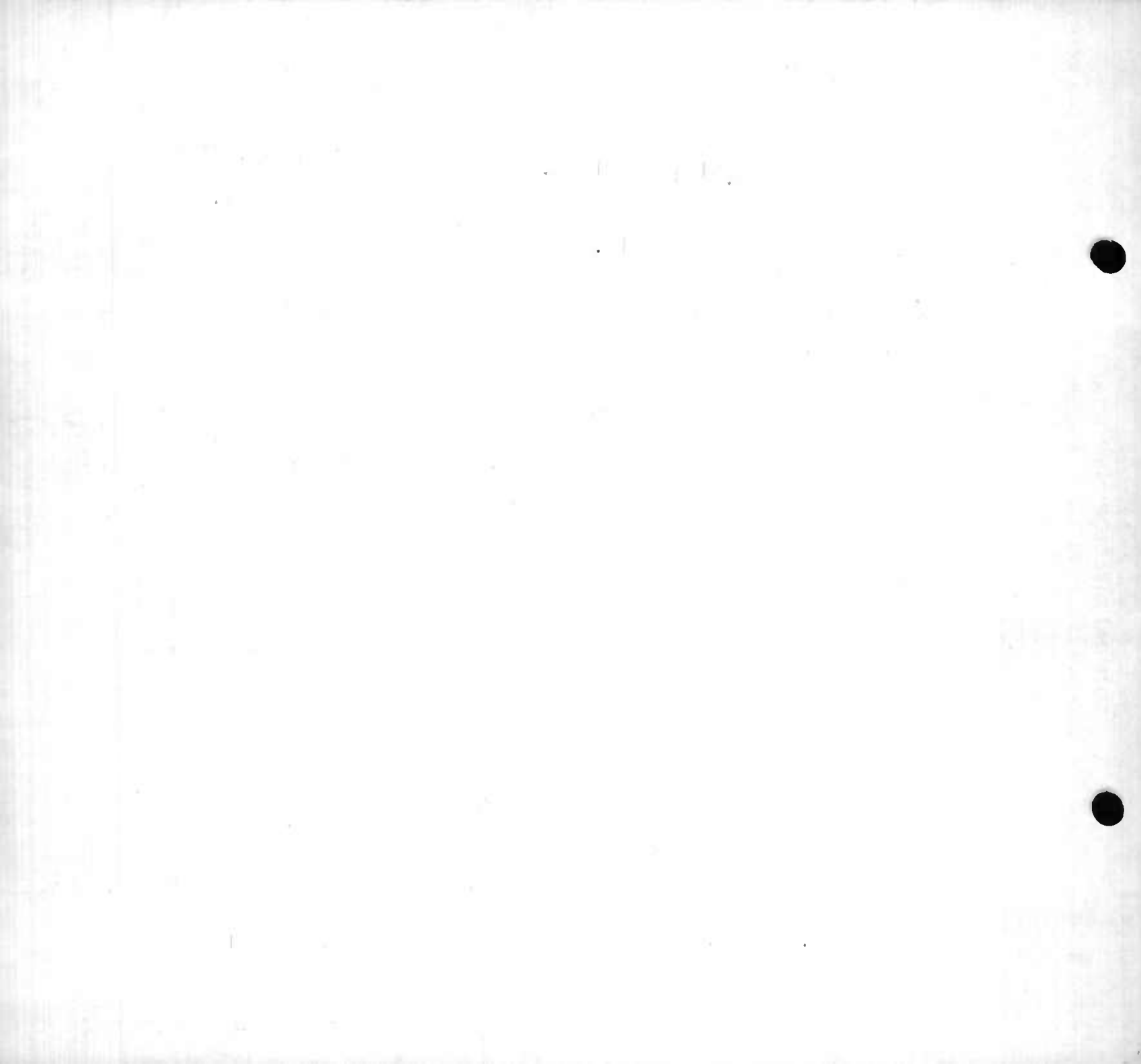


Released Non-Med. by Dr. Hirsch M.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5264		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5264	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Nathan L. White		2. DATE AND HOUR OF DEATH 5/28/1967 11 ¹⁵ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHN HOPKINS HOSPITAL.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city, write RURAL and township) BALTIMORE, 15 7-03 D. STREET ADDRESS (If rural, give location) 2327 EAGER ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 8-6-1918 [?]	9. AGE (In years lost birthday) 48	If Under 1 Tr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Elizabeth City, N. C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ELIHU WHITE		14. MOTHER'S MAIDEN NAME BUNAH GALLOPS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-22-8912		17. INFORMANT Rebecca Thornton 1704 E. 25th St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) ? Brain Metastases DUE TO (B) ? CA. of Lung DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ? weeks ? months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPST? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 5/27 1967 to 5/28 1967 that (we) last saw the deceased alive on 5/28 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE S. W. Spaulding STEPHEN W. SPAULDING				23B. DATE SIGNED 5/28/1967	
23C. PHYSICIAN'S NAME (Type) STEPHEN W. SPAULDING		23D. ADDRESS M.D. THE JOHN HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6-2-67		24C. NAME OF CEMETERY or CREMATORY Gallops Cemetery	
24D. LOCATION N. C.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 31 1967		25B. NAME OF REGISTRAR R. E. E. Taylor		25C. FUNERAL DIRECTOR Randolph Collick 2431 E. Oliver St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5265	
BIRTH NO. 67 5265		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Edna G. Beever		2. DATE AND HOUR OF DEATH May 25, 1967 1:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hosp		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 3512 Chesto field Ave	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) married	8. DATE OF BIRTH 10/3/98	9. AGE (in years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John W. Franks		14. MOTHER'S MAIDEN NAME Etta Barnett	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph Beever	
ADDRESS same					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) SEPTIC PULMONARY INFARCT		CAUSE OF DEATH (A) DUE TO PULMONARY EMBOLUS - 1-2 WK		INTERVAL BETWEEN ONSET AND DEATH 1-2 WK	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO PHLEBOTOMOSIS		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 22 19 67 to May 25 19 67 , that (I) (we) last saw the deceased alive on May 25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Michael Gould M.D.				23B. DATE SIGNED 5/25/67	
23C. PHYSICIAN'S NAME (Type) W. MICHAEL GOULD M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-29-67		24C. NAME of CEMETERY or CREMATORY Bmoreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR John C. Miller		25C. FUNERAL DIRECTOR Miller Inc-6415 Belair Road-21206	
ADDRESS					

Edna C. Jones

Marjorie General Hwy

F W 10/2/28

Marjorie

John W. Frank

Marjorie

Marjorie 10/2/28

Marjorie

Brittany

3212 Chestnut Ave

10/2/28

Marjorie

U.S.A.

Edna C. Jones

Marjorie

10/2

Marjorie 10/2/28

Marjorie

10/2/28

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-5312		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5266	
BIRTH NO. 67 5266		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Elizabeth A. Kennedy</i>		2. DATE AND HOUR OF DEATH <i>5-31-67 9:00 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give town) <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp.</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1248 William St.</i>	
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>10-8-1908</i>	9. AGE (In years last birthday) <i>58</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Importers</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SECRE.</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>	
13. FATHER'S NAME <i>Louis Klingenberg</i>		14. MOTHER'S MAIDEN NAME <i>Mary Schwemm</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family - Jane</i>	
18. <i>426.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute myocardial infarction</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that this (this hospital) attended the deceased from <i>5-27</i> 19 <i>67</i> to <i>5-31</i> 19 <i>67</i> , that we (we) last saw the deceased alive on <i>5-31</i> 19 <i>67</i> and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jose B. Corvera, M.D.</i>				23B. DATE SIGNED <i>5-31-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Jose B. Corvera</i>				23D. ADDRESS <i>1213 Light Street.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>6/3/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Louisa Park</i>	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 1 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>W. S. (244)-130 E. Fort Ave</i>	

M-6501

67 5267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5267

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MORAN, EDITH H.

2. DATE AND HOUR OF DEATH

MAY 27 1967

6:35A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

HALETHORPE

D. STREET ADDRESS (If rural, give location)

1913 HALETHORPE AVE.

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

7/3/85

9. AGE (In years
lost birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

WILLIAM W. Zimmerman

14. MOTHER'S MAIDEN NAME

KATHERINE HECHTER

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NONE

NONE

16. SOCIAL
SECURITY NO.

220-05-3437

17. INFORMANT

ADDRESS

ST. AGNES HOSPITAL; BALTIMORE, MD. 2122

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

18. CAUSE OF DEATH

ACUTE CORONARY OCCLUSION

INTERVAL BETWEEN
ONSET AND DEATH

2 DAYS

A.S.C.V.D.

20 PLUS YRS.

EMPHYSEMA

20 PLUS YRS.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

FRACTURE RIGHT FEMUR

2 WEEKS

19A. DATE OF OPERATION

5-18-67

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED
FRACTURED CHL

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

HOME

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

634 BRAESIDE RD.

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

5/17/67

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☒

21F. HOW DID INJURY OCCUR?

PATIENT FELL to floor

22. I certify that (X) (this hospital) attended the deceased from MAY 17 19 67 to MAY 27 19 67,
that (X) (we) last saw the deceased alive on MAY 27 19 67 and that in (X) (our) opinion death occurred on the date
and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.

23A. SIGNATURE

Frank M. Detorie

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

5/28/67

23C. PHYSICIAN'S
NAME (Type)

FRANK DETORIE,

M.D.

23D. ADDRESS

ST. AGNES HOSPITAL; CATON & WILKENS AVE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/31/67

24C. NAME OF CEMETERY or CREMATORY

Western Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 1 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Ambrose Inc

ADDRESS

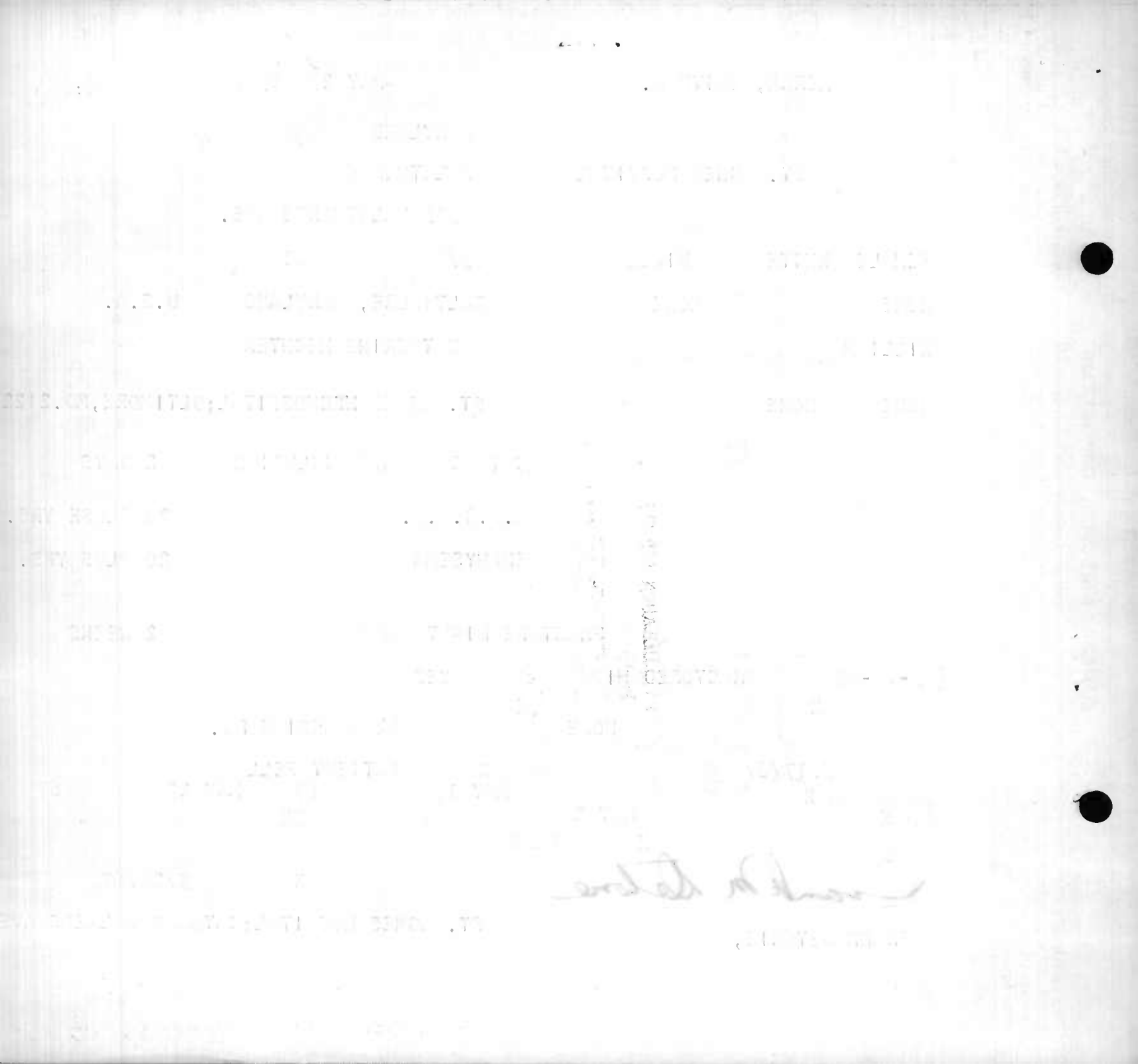
1328 Sulphur Sp Rd

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATION APPROVED BY: M.D.

M.D.



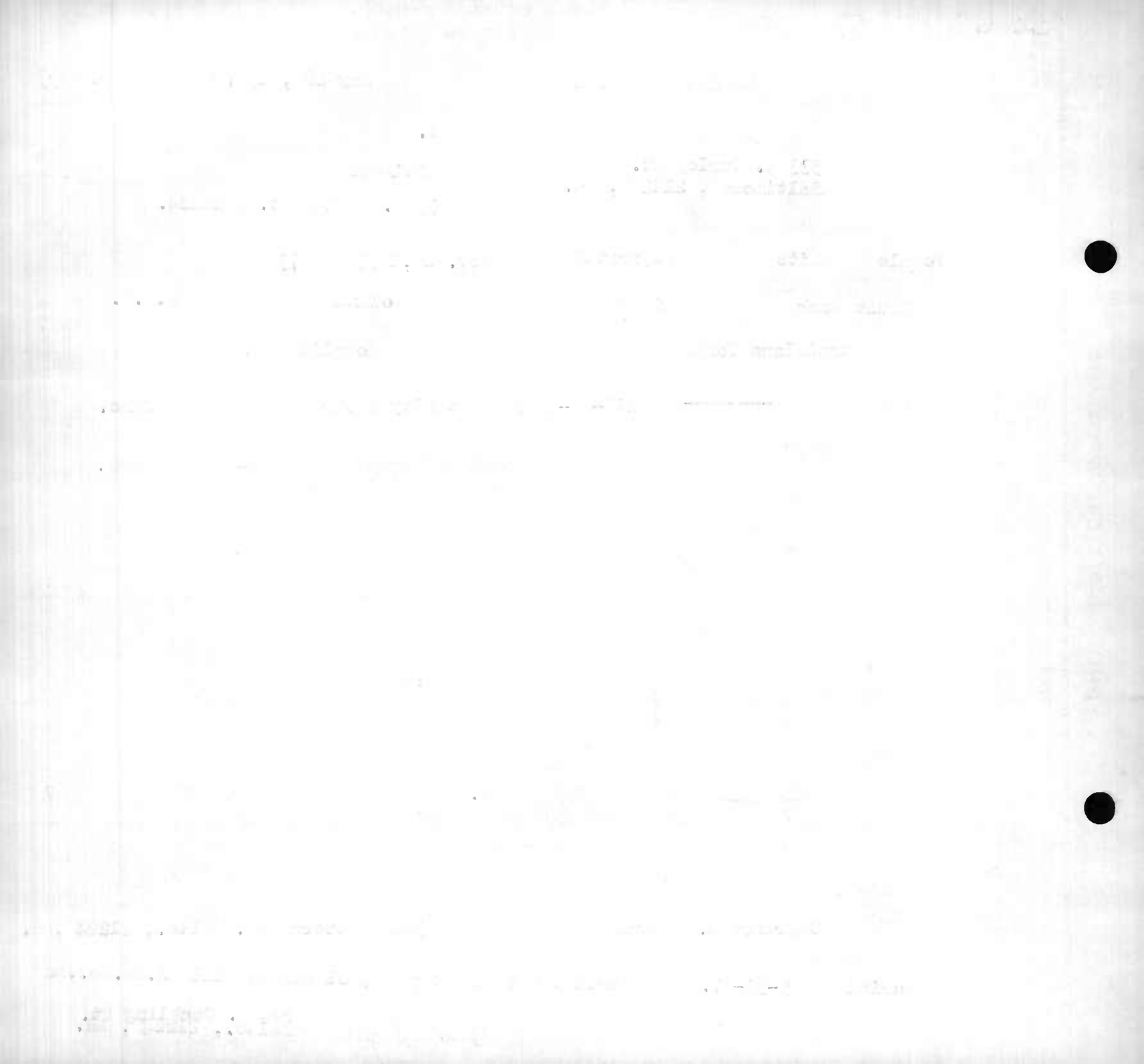
Handwritten signature

1
B-400

BIRTH NO. 67 5268		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5268	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MARY E. BAILEY		2. DATE AND HOUR PRONOUNCED DEAD May 29, 1967 12:36 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL (DOA)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 3648 Washington Boulevard			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 4/22/13	9. AGE (In years last birthday) 54	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Amos		14. MOTHER'S MAIDEN NAME Nina Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary J. Kibler 3648 Washington Blvd	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty Alteration of Liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/1/67		23C. NAME OF CEMETERY or CREMATORY Lorraine Cemetery Baltimore, Maryland	
23D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24C. FUNERAL DIRECTOR Gambino, Inc. 1328 Sulphur Sp. Rd.		24D. ADDRESS			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

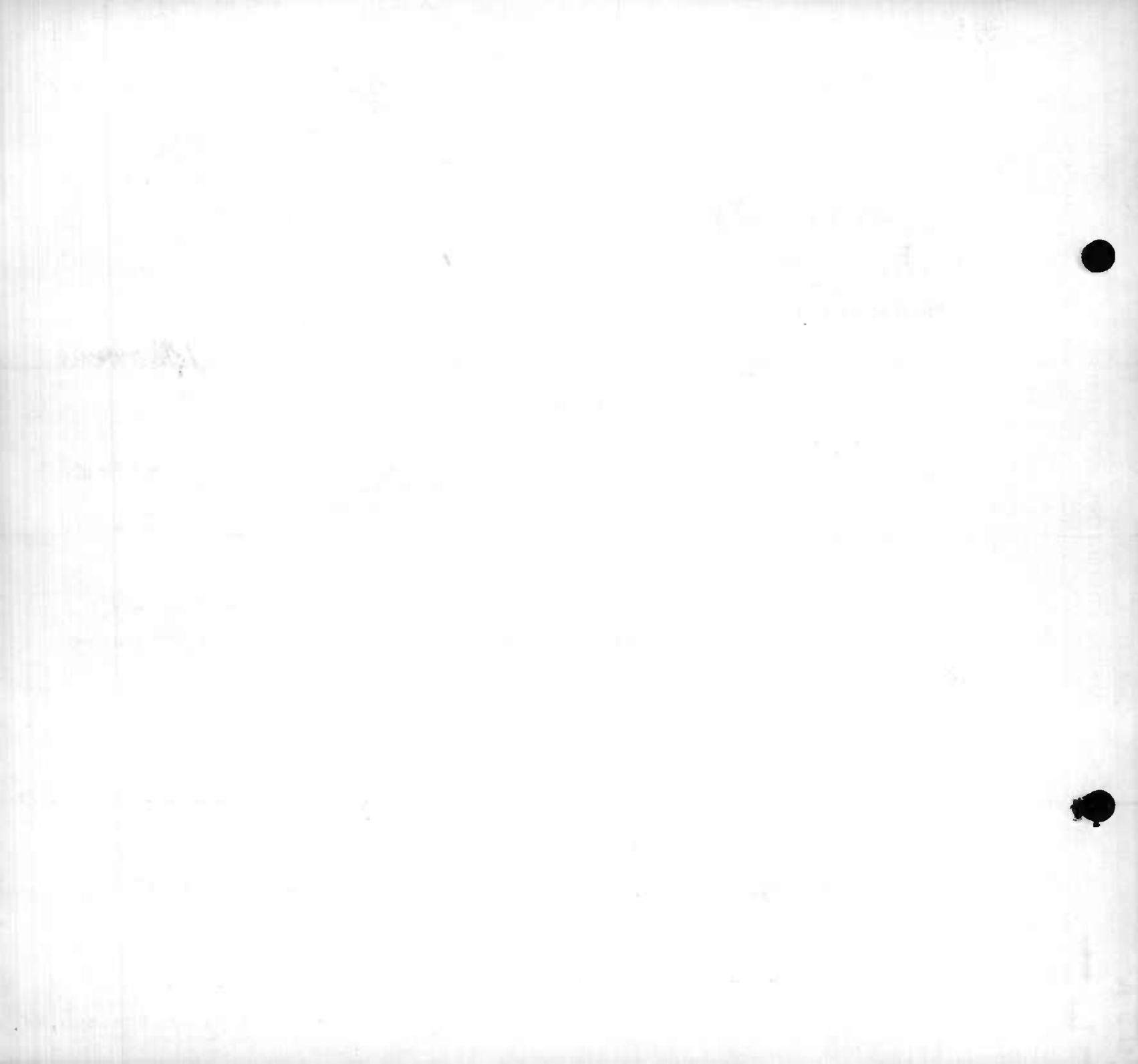
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5269	
BIRTH NO. 67 5269											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) KATHERINE NATUR						2. DATE AND HOUR OF DEATH May 28, 1967 @ 2:50 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 00						A. STATE Md.					
(If not in hospital or institution, give street address or location) 533 S. Curley St. Baltimore, 21224, Md.						B. COUNTY					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore						D. STREET ADDRESS (If rural, give location) 533 S. Curley St. # 21224.					
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated		8. DATE OF BIRTH Nov. 24, 1893		9. AGE (In years last birthday) 73		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10B. KIND OF BUSINESS OR INDUSTRY At Home				11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanislaus Yonda						14. MOTHER'S MAIDEN NAME Rosalie ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-30-3363		17. INFORMANT Stanley Natur				ADDRESS Same.	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease						CAUSE OF DEATH (A) Arteriosclerotic Cardio-vascular Disease (B) (C) INTERVAL BETWEEN ONSET AND DEATH 5 yrs.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Feb. 12 19 63 to May 28 19 67 , that (I) (we) lost saw the deceased alive on May 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
23A. SIGNATURE <i>Clarence W. LeDoux</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/31/67			
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux						23D. ADDRESS 3023 Eastern Ave. Balto., 21224, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-31-67.		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd. Ba. Co., Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967				25B. NAME OF REGISTRAR <i>Robert E. Sisk</i>		25C. FUNERAL DIRECTOR <i>Charles J. Jailer</i>		ADDRESS 901 S. Conkling Balto., 21224, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 5270		67 5270	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Myrtle Santman		5/27/67 4:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
38 University Hospital		Md. Washington Co.			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Hagerstown 71-03			
		D. STREET ADDRESS (If rural, give location)			
		617 Marion ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	W	Married	6/17/08	58	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		—		Pennsylvania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William C. Koons		Garrie Belle McPherrin		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		215-18-2467		PT. - see above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		24 hrs.	
ANTECEDENT CAUSES		(B) DUE TO		2 wks.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		aorto femoral bilat. bypass -		6 wks	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		excision of iliac graft -		4 days	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
5/23 ; 4/24	bilat. aorto-iliac occlusion	yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/8 1967 to 5/27 1967 that (I) (we) lost saw the deceased alive on 5/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
B. Ann Ward				5/27/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial	5-30-67	Rose Hill Cemetery		Hagerstown, Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
JUN 1 1967	Robert E. Farland	Minnich Funeral Home		Hagerstown, Md.	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.67 5271
BIRTH NO.
M.E. CASE NO.

67 5271

1. NAME OF DECEASED (Type or Print) JOHN MCLEAN		2. DATE AND HOUR PRONOUNCED DEAD May 28, 1967 5:25 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 925 N. Gilmore Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S	8. DATE OF BIRTH DEC 22 - 1959	9. AGE (in years last birthday) 7	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ray McLean		14. MOTHER'S MAIDEN NAME BERTHA HARRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT BERTHA HARRIS 925 N Gilmore St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 812.4 MASSIVE INTERNAL BLEEDING DUE TO laceration of liver and adrenal gland		CAUSE OF DEATH (A) MASSIVE INTERNAL BLEEDING DUE TO laceration of liver and adrenal gland (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Gilmore St. south of Mosher St. 16-02	
21D. TIME OF INJURY (APPROX.) May 28 '67 P.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian struck by car	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/29/67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/1/67		23C. NAME OF CEMETERY or CREMATORY MT AUBURN	
23D. LOCATION (City, town, or county) (State) BALTIMORE		24A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		24B. NAME OF REGISTRAR Robert E. [illegible]	
24C. FUNERAL DIRECTOR Manhattan P. [illegible]		24D. ADDRESS 638 N Gilmore St			

725

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 32-55-83	
BIRTH NO. 67 5272				67 5272	
M.E. CASE NO.				300 A M.	
1. NAME OF DECEASED (Type or Print) Holmes, Carrie			2. DATE AND HOUR OF DEATH 5/29/67		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital 38			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3912 Woodridge - Rd.		
5. SEX Female	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 9/8/25	9. AGE (In years last birthday) 41	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARMAID		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT admission record		
18. I 171 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 255-307 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Carcinoma of cervix (A) Pelvic hemorrhage (B) Pelvic infection (C) Carcinoma of cervix Radiation necrosis			INTERVAL BETWEEN ONSET AND DEATH Unknown		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Radiation necrosis					
19A. DATE OF OPERATION 03/14/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pelvic Excavitation		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/7/67 19 to 5/29 19 67 , that (I) (we) last saw the deceased alive on 5/29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fred R. Eilben M.D.			23B. DATE SIGNED 5/29/67		23C. PHYSICIAN'S NAME (Type) FRED R. EILBEN M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/3/67		24C. NAME OF CEMETERY or CREMATORY Mt Auburn
24D. LOCATION (City, town or county) (State) BALTIMORE			25A. DATE RECEIVED BY HEALTH DEPT. JUN 1 1967		
25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR James H. Hays		
25D. ADDRESS 638 N. Gilmor St					

Handwritten notes at the top right, possibly a date or reference.

Handwritten notes on the left side, including "BATCHES" and "SIS" (possibly a name or title).

Handwritten notes in the upper middle section, including "Dissolved" and "BAR WARD".

Handwritten notes in the lower middle section, including "MAR 1952" and "MAR 1954".

A horizontal line of handwritten text across the middle of the page.

- (A) 1st floor
- (B) 2nd floor
- (C) 3rd floor

Handwritten text below the list, possibly a date or reference.

Handwritten text in the lower middle section, including "on" and "11/11/52".

Handwritten text below the previous line, possibly a name or title.

Handwritten notes on the bottom left, including "2/1/52" and "2/1/52".

Handwritten notes on the bottom right, including "2/1/52".

Handwritten notes at the bottom left, including "2/1/52" and "2/1/52".

Handwritten notes at the bottom right, including "2/1/52" and "2/1/52".

B-650

BALTIMORE CITY HEALTH DEPARTMENT		67 5273	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No. 67 5273	
BIRTH NO. 67 5273		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) JO ANN BROWN		2. DATE AND HOUR PRONOUNCED DEAD 5-27-67 6:45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, If institution, residence before, admission) A. STATE Maryland B. COUNTY Caroline Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Denton D. STREET ADDRESS (If rural, give location) Rt. #1 - Box #38	
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 10-20-1956
9. AGE (In years last birthday) 10		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Child		10B. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Pocomoke, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Brown	
14. MOTHER'S MAIDEN NAME Irene E. Manley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No No	
16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS William Brown (father) same as above	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) 2nd and 3rd degree burns over 60% of body surface DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Conflagration DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Town Dump	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Denton Town Dump - 1 mile East of Denton, Maryland		21D. TIME OF INJURY (APPROX.) 3 5 '67 3:00 PM	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Engulfed in ball of fire from can of liquid which had been bursted by a boy shooting rats on dump	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5-31-1967	
23C. NAME of CEMETERY or CREMATORY Spring Grove Cemetery		23D. LOCATION (City, town, or county) (State) Denton, Maryland, Caroline Cy	
24A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		24B. NAME OF REGISTRAR R. S. Fisher	
24C. FUNERAL DIRECTOR Charles W. Hill, Mortician Denton, Md.		24D. ADDRESS	

11948.2



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 67 5274				
BIRTH NO. 67 5274					MAY 30, 1967				
M.E. CASE NO.					1:15 A.M.				
1. NAME OF DECEASED (Type or Print) MC ALLISTER, JAMES WILLIAM					2. DATE AND HOUR OF DEATH				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229					A. STATE PENNA. B. COUNTY PHILADELPHIA 7521 RUGBY ST.				
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 02-25-91		9. AGE (In years lost birthday) 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME GEORGE					14. MOTHER'S MAIDEN NAME BLANCHE (OBENCHE IN)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES (NAVY) WW1					16. SOCIAL SECURITY NO. 159090722				
17. INFORMANT ADDRESS ST. AGNES RECORDS - BALTO., MD. 21229									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Septicemia & Pulmonary atelectasis. (B) Multiple liver abscesses. (C) Cholelithiasis				
19. DATE OF OPERATION					20. AUTOPSY? (Yes or No)				
21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
23. TIME OF INJURY (APPROX.)					24. HOW DID INJURY OCCUR?				
25. I certify that (X) (this hospital) attended the deceased from MAY 23, 1967 to MAY 30, 1967, that (X) (we) lost saw the deceased alive on MAY 30, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) view the body after death.									
26. SIGNATURE L. E. DIBOS					27. DATE SIGNED				
28. PHYSICIAN'S NAME (Type) XXXXXXXXXX P DIBOS					29. ADDRESS WILKENS & CATON AVES ST. AGNES HOSPITAL - BALTO., MD. 21229				
30. BURIAL CREMATION, REMOVAL (Specify) Burial					31. DATE 6-2-1967				
32. NAME OF CEMETERY or CREMATORY Philadelphia					33. LOCATION (City, town, or county) (State) Philadelphia, Pa.				
34. DATE REC'D BY HEALTH DEPT. JUN 1 1967					35. NAME OF REGISTRAR R. E. DIBOS				
36. FUNERAL DIRECTOR E. C. Higgins					37. ADDRESS Ellicott City Md				

111 321 4

591734

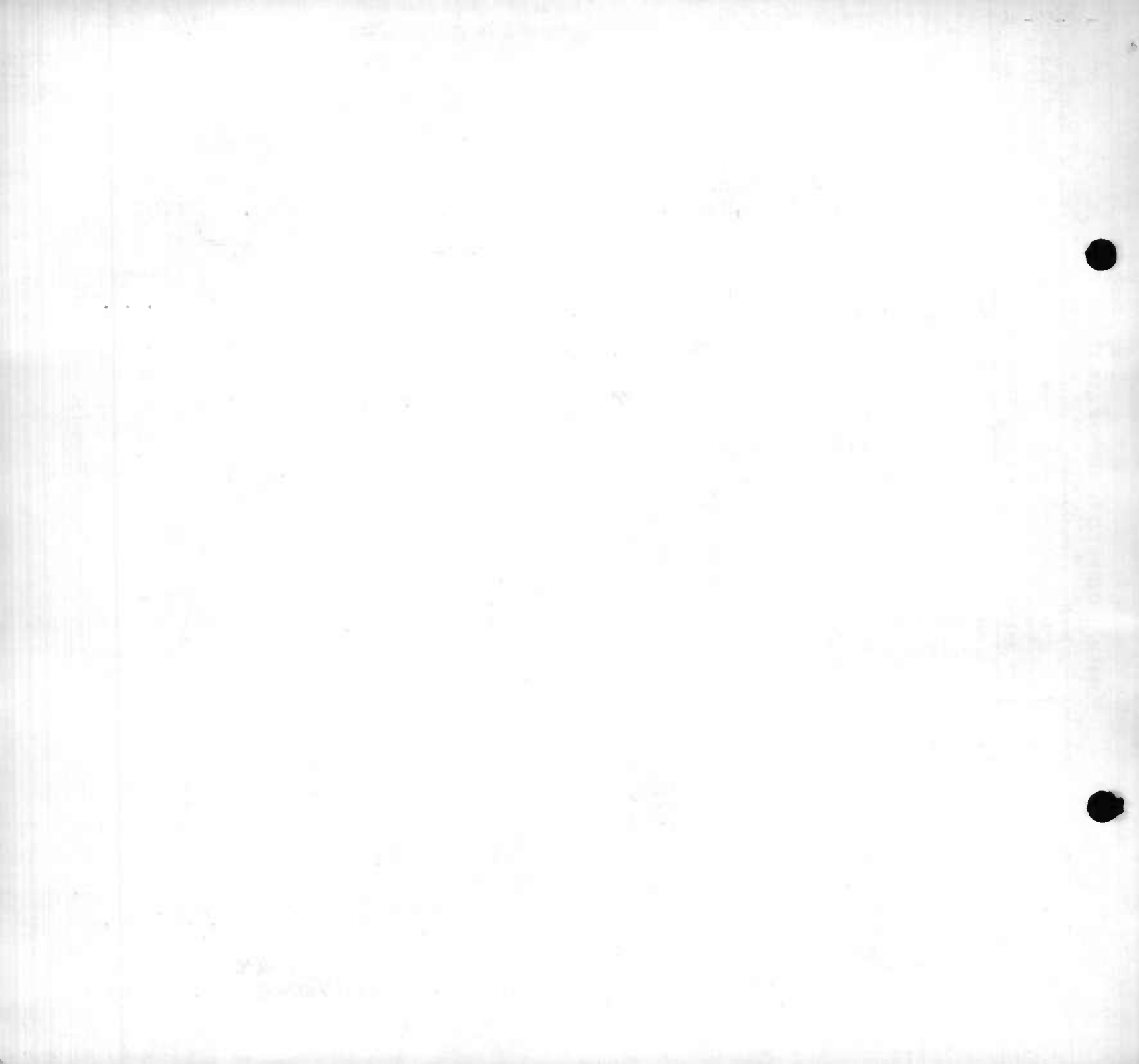
1

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U.S. - 46067 5275				CITY OF BALTIMORE		Registered No. 67 5275	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <i>Charles Wheeler</i>				2. DATE AND HOUR OF DEATH <i>5-30-67</i> <i>1 5 10 A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				A. STATE <i>Maryland</i> B. COUNTY			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				D. STREET ADDRESS (If rural, give location) <i>1233 Washington Blvd. 21230</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED <i>Married</i>	8. DATE OF BIRTH <i>3-28-1946</i>	9. AGE (In years last birthday) <i>21</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Upsholster</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Upsholstering Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Robert E. Wheeler</i>				14. MOTHER'S MAIDEN NAME <i>Anna Hannah Burton</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>P</i>		17. INFORMANT ADDRESS <i>Records: BCM: 4940 Eastern Avenue 21224</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Ewing's Sarcoma</i> <i>metastasis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>6 years</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Nat While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4-6-67</i> to <i>5-30</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5-30</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>James W. Keller</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5-30-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>James W. Keller</i>				23D. ADDRESS <i>4940 Eastern Avenue, Baltimore, Maryland</i> <i>Baltimore City Hospitals</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/6/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Landon Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 1 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Keller</i>		25C. FUNERAL DIRECTOR <i>John J. Brown</i>		ADDRESS <i>Son. Inc. 901 Thallum St. (Balt. 23, Md.)</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO. 67 5276				Registered No. 67 5276							
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) WALT, CATHERINE MARGARET				2. DATE AND HOUR OF DEATH MAY 30, 1967 3:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 21222 - Baltimore Co.							
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Dundalk							
				D. STREET ADDRESS (If rural, give location) 2519 WEST WOODWELL ROAD							
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 03-27-08	9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ANTHONY BERRAN (DEC 'D)				14. MOTHER'S MAIDEN NAME ELIZABETH (KIMMEL) (DEC 'D)							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 178-05-5698		17. INFORMANT ADDRESS ST. AGNES RECORDS-BALTIMORE, MD. 21229					
18. CAUSE OF DEATH 43471 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 28, 1967 to MAY 30, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 30, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (<input checked="" type="checkbox"/> (We) (did) XXXX view the body after death.											
23A. SIGNATURE John B. Herts				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5/30/67			
23C. PHYSICIAN'S NAME (Type) JOHN B. HERTS,				23D. ADDRESS M.D. WILKENS & CATON AVES ST. AGNES HOSPITAL-BALTO., MD. 21229							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/2/67		24C. NAME of CEMETERY or CREMATORY Sacred Heart Of Jesus Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.							

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

10-10-1967

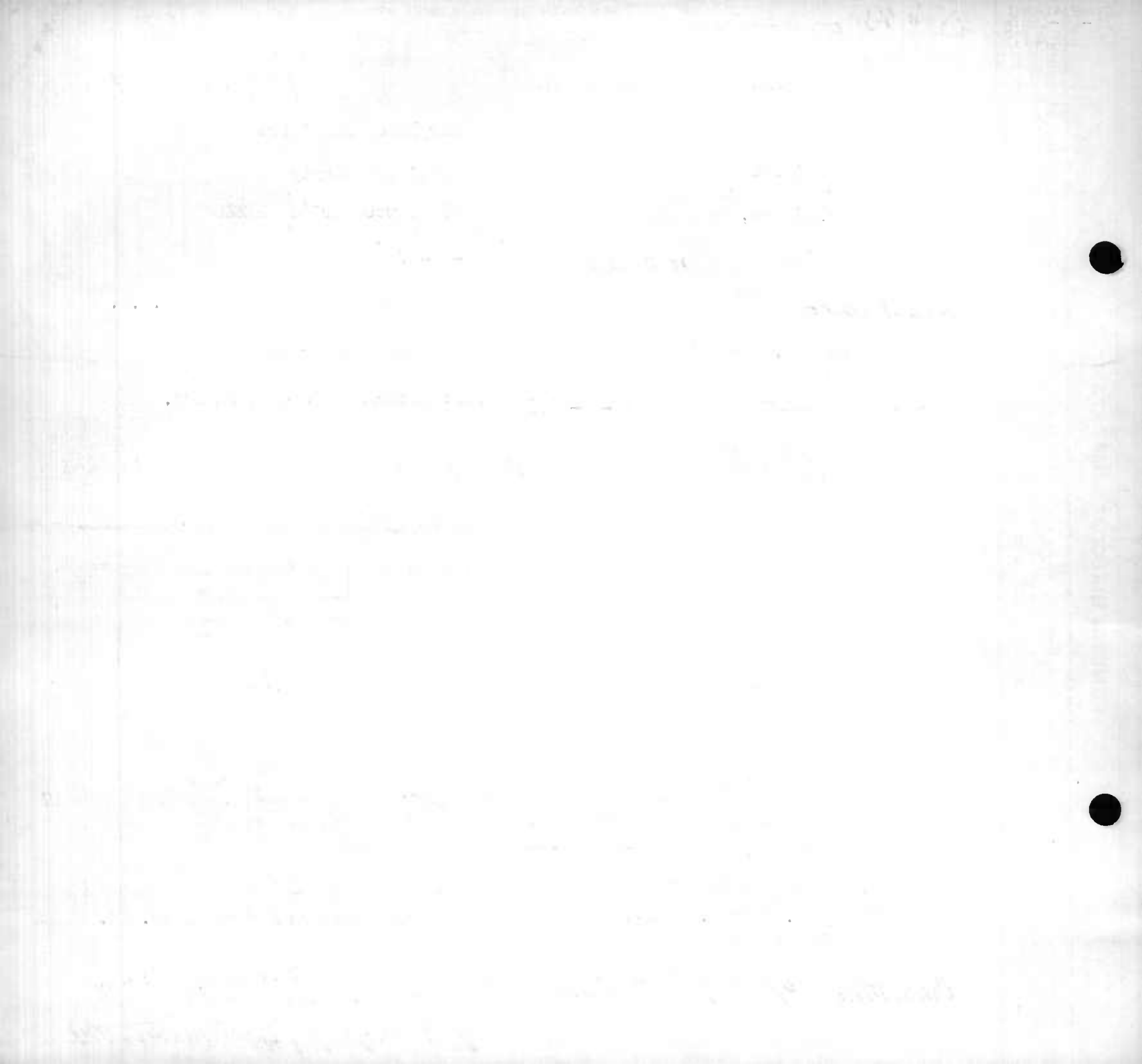
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5277				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5277	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) THOMAS FISHER				2. DATE AND HOUR OF DEATH 5-29-67 305 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. OF BALTIMORE, INC. 42				A. STATE MARYLAND B. COUNTY CARROLL Co.			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) WESTMINSTER 36-00			
				D. STREET ADDRESS (If rural, give location) RT. 4 GORSUCH. Rd			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 5-7-90	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME not known			14. MOTHER'S MAIDEN NAME ELLA FISHER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I.			16. SOCIAL SECURITY NO. none		17. INFORMANT MRS. ANNA BITZEL FISHER		
					ADDRESS WESTMINSTER MD. RD #4		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Rocky Mountain Spotted Fever				CAUSE OF DEATH Rocky Mountain Spotted Fever		INTERVAL BETWEEN ONSET AND DEATH 10 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-28 19 67 to 5-29 19 67 , that (I) (we) last saw the deceased alive on 5-29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leslie Abramowitz				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/29/67	
23C. PHYSICIAN'S NAME (Type) Leslie Abramowitz				23D. ADDRESS SINAI HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/1/67		24C. NAME OF CEMETERY or CREMATORY Leisters Cemetery		24D. LOCATION (City, town, or county) (State) Rural, Westminster, Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR Paul E. Fisher		25C. FUNERAL DIRECTOR ADDRESS 5850 Maple, Jr. Westminster, Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-645 67 5278		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5278	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED	
67 5278				ADELINE KERLIN	
2. DATE AND HOUR OF DEATH		5/29/67 7:55 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
(If not in hospital or institution, give street address or location)		Maryland Baltimore			
31		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Baltimore City Hospitals		Baltimore County			
4940 Eastern Avenue		D. STREET ADDRESS (If rural, give location)			
Baltimore, Maryland 21224		25 Dogwood Drive 21220			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	White	WIDOWED	9-28-77	89	HOUSE-WIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Germany	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Koster, Christien		Melena Von Bergen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		218-30-2493		BCH: Records 4940 Eastern Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) PNEUMONIA		24 hrs.	
ANTECEDENT CAUSES		(B) ASCVD		Several years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Pulmonary edema		4 days	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		ASCVD generalized	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 20th 1967 to May 29th 1967, that (I) (we) last saw the deceased alive on May 29th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
John C. Whelton				5/29/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. John C. Whelton		4940 Eastern Avenue Balto. Md. 21224			
JOHN C. WHELTON M.D.		BALTIMORE CITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		6/2/67		Fort Lincoln Crematory	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
3201 Bladensburg Road Washington D.C. 18		Robert E. Schuyler		J. S. Myers, Jr., Westminister, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 1 1967		Robert E. Schuyler		J. S. Myers, Jr., Westminister, Md.	



FUNERAL DIRECTOR: IMPORTANT

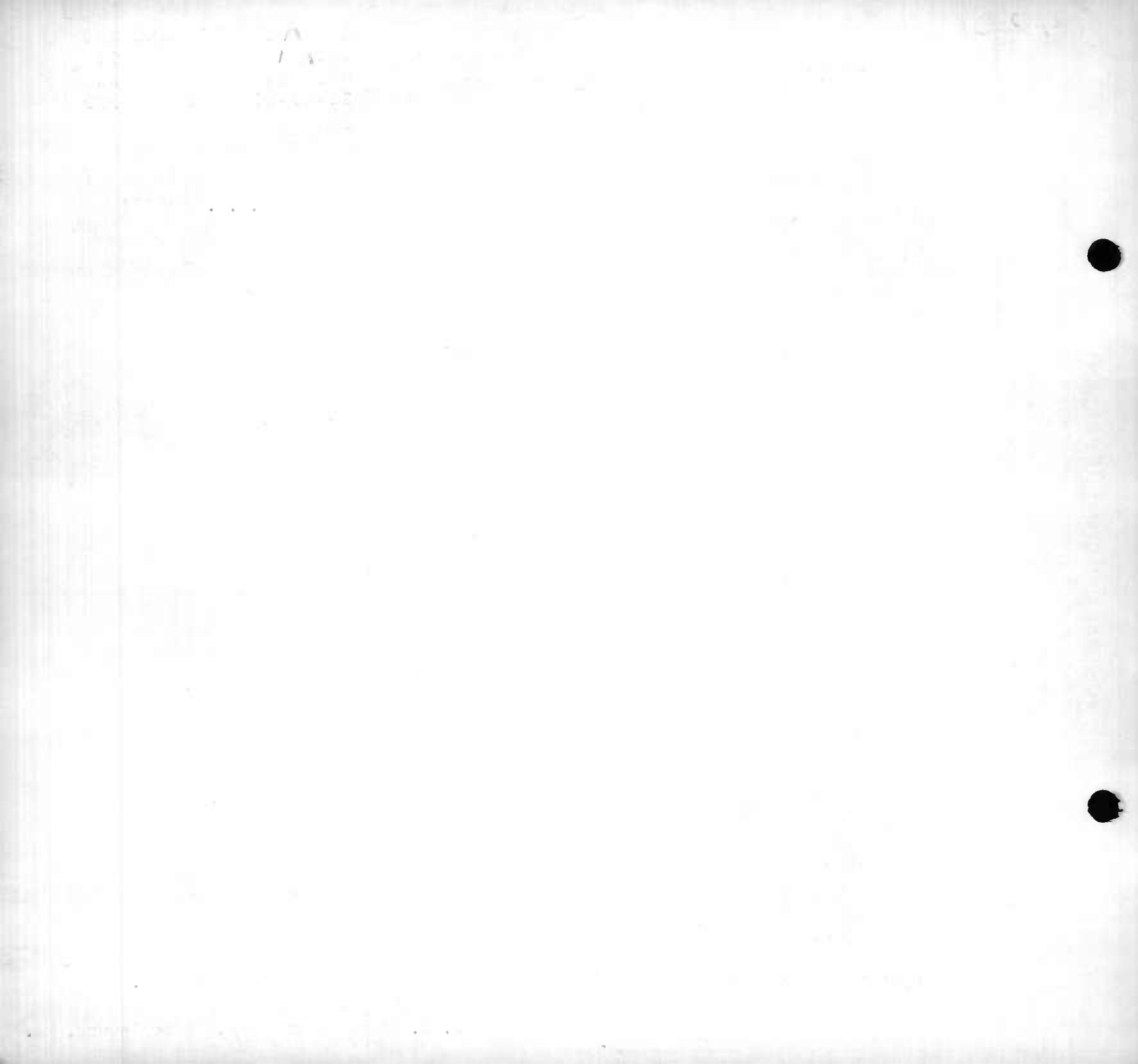
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department						Registered No. 67 5279	
BIRTH NO. 67 5279		CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BLATCHLEY, ENZA L. Lowndes			2. DATE AND HOUR OF DEATH may 22. 1967 11 45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 12-02			
				D. STREET ADDRESS (If rural, give location) 302 Birkwood Place			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 07-19-95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Montgomery Payne, T. Martin				14. MOTHER'S MAIDEN NAME Sarah unknown E. Foxwell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-18-0491		17. INFORMANT ADDRESS Mr. H. P. Brinsfield (nephew from church)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) Arteriosclerotic heart disease DUE TO (B) Myocardial Infarction DUE TO (C) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 13 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from may 9, 1967 to may 22, 1967 , that (we) lost saw the deceased alive on may 22, 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Giselle T. Bretz				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED may 22. 1967	
23C. PHYSICIAN'S NAME (Type) Giselle T. Bretz				23D. ADDRESS M.D. Union Mem. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 24, 1967		24C. NAME OF CEMETERY or CREMATORY Brookview Cemetery		24D. LOCATION (City, town, or county) (State) Brookview, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR J. J. Frampton and Son		ADDRESS Frampton and Son, Federalsburg, Md.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5280		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5280	
M.E. CASE NO. 5235					
1. NAME OF DECEASED (Type or Print) ELLIE Lee Quales			2. DATE AND HOUR OF DEATH 5/18/67 5:00 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence, date of admission) A. STATE Mo B. COUNTY Dorchester Co.		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) HURLOCK Mo. 59-00		
			D. STREET ADDRESS (If rural, give location) R.F.D. Box 121		
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 2/22/67	9. AGE (In years last birthday) 26	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Willie Savage			14. MOTHER'S MAIDEN NAME Hattie Mae Quales		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ELLIE T. S. TOKAR M.D. UNIV. Hosp.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 760.01			CAUSE OF DEATH (A) Severe Brain Damage (Congenital) (B) (C) INTERVAL BETWEEN ONSET AND DEATH 2 mos 26 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-18-67 19 to 5-18-67 19, that (I) (we) last saw the deceased alive on 5-18-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elliott S. Tokar				23B. DATE SIGNED 5/18/67	
23C. PHYSICIAN'S NAME (Type) ELLIOT S. TOKAR		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 22, 1967		24C. NAME OF CEMETERY or CREMATORY Skinner's Run Cemetery	
				24D. LOCATION (City, town, or county) (State) Near Williamsburg, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR Elliot S. Tokar		25C. FUNERAL DIRECTOR G. J. Brampton and Son, Federalsburg, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5281	
BIRTH NO. 67 5281				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
M.E. CASE NO.				Adger, President		5-27-67 1:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				A. STATE Maryland		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		14-0-2	
				D. STREET ADDRESS (If rural, give location)		1735 McCulloh Street	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 3-16-15	9. AGE (In years lost birthday) 53 yrs.	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Carrietta Howard - daughter		ADDRESS SAME
18. 241X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) C.V.A. DUE TO Asthma, Pulmonary infection			
				(B) DUE TO Heart failure & Hypertension			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 26, 1967 to May 27, 1967, that (I) (we) lost saw the deceased alive on May 27, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lizarazo				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-29-67	
23C. PHYSICIAN'S NAME (Type) LIZARAZO				23D. ADDRESS M.D. 1514 Division Street Balto., Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/1/67		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Eadolphus Halstead		ADDRESS 1206 W North Ave	

LIBRARY
- 1000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5282		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5282	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Gilbert Abraham		2. DATE AND HOUR OF DEATH 5-30-67		5:49 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 14-03 D. STREET ADDRESS (If rural, give location) 2816 McCulloh Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	8. DATE OF BIRTH 3-28-11	9. AGE (In years last birthday) 56 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-Active Welfare		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Delores Matthews - niece	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) PULMONARY EDEMA. DUE TO (B) CONGESTIVE HEART FAILURE. DUE TO (C) PULMONARY TBC.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		MALNUTRITION. DEHYDRATION ANEMIA			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 29, 1967 to May 30, 1967, that (I) (we) last saw the deceased alive on May 30, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lizarrazo		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-31-67	
23C. PHYSICIAN'S NAME (Type) LIZARRAZO		23D. ADDRESS M.D. 1514 Division Street Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/3/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR Robert E. Finkley		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave	

Pulmonary Edema

Coronary Heart Failure

Pulmonary TBC

Malnutrition, Dehydration
Anemia

Isaiah

LIZABETH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5283	
BIRTH NO. 67 5283		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George Shields		May 25, 1967 10:45 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland 21217		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-02 D. STREET ADDRESS (If rural, give location) 829 Whitelock Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 1892	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-Active Welfare		10B. KIND OF BUSINESS OR INDUSTRY Welfare		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Lily Summerville	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 465X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Pulmonary Embolism (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Immediate	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Smoking; BPH & Urinary Retention Relieved					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 14, 19 67 to May 25, 19 67, that (I) (we) last saw the deceased alive on May 25, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rosario Bello		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 26, 1967	
23C. PHYSICIAN'S NAME (Type) Rosario Bello		23D. ADDRESS M.D. 1514 Division Street-Baltimore, Maryland 21217			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/2/67		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967			
25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North Ave W North	



BIRTH NO.

5284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67

5284

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM JOSEPH (LEROY) GIBBS

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

1:00 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

413 Robert Street - Baltimore 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10-15-46

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Gene Lyles

14. MOTHER'S MAIDEN NAME

Margaret Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs Carter,

ADDRESS

same

18. 28749

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Overdose of narcotics
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Unknown

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Unknown

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

Unknown

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Ingested overdose of narcotics

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-27-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/3/67

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 1 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

10/15

WALSH & COMPANY
100 N. LAKE ST.
CHICAGO, ILL.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5285	
BIRTH NO. 67 5285		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Virginia Hawkins</i>		2. DATE AND HOUR OF DEATH <i>May 29, 1967</i> 5 ²⁰ A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University of Maryland Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>Anne Arundel Co.</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Glen Burnie</i>		52-00	
				D. STREET ADDRESS (If rural, give location) <i>1503 Saunders Way</i>			
5. SEX <i>Female</i>	6. RACE <i>Cauc</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12/14/87</i>		9. AGE (In years last birthday) <i>79</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework (Ret)</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Walter S. Adams</i>				14. MOTHER'S MAIDEN NAME <i>Mary Ball</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>(Sister) MRS Margaret Vegedes</i>		ADDRESS <i>RT #1 Boone W. Carolina</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>4-20-01</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <i>Suspected Acute Pulmonary Embolus</i> DUE TO		<i>1-2 hrs. ?</i>	
				(B) <i>Atrial Fibrillation with Congestive Heart Failure</i> DUE TO		<i>3 wks.</i>	
				(C) <i>Arteriosclerotic Heart Disease</i> DUE TO		<i>? Years</i>	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/13</i> 19 <i>67</i> to <i>5/29</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5/28</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>R.H. Anderson</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5/29/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>R.H. Anderson</i>				23D. ADDRESS M.D. <i>University of Maryland Hospital Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>June 1, 1967</i>		24C. NAME of CEMETERY or CREMATORY <i>U.S. National Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 1 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Spillane</i>		25C. FUNERAL DIRECTOR <i>Richard V. Singleton</i>		ADDRESS <i>Glen Burnie, Md</i>	

1. The first part of the paper is devoted to a general discussion of the problem.

2. The second part is devoted to a detailed analysis of the case of a single particle.

3. The third part is devoted to a detailed analysis of the case of a system of particles.

4. The fourth part is devoted to a detailed analysis of the case of a system of particles.

5. The fifth part is devoted to a detailed analysis of the case of a system of particles.

6. The sixth part is devoted to a detailed analysis of the case of a system of particles.

7. The seventh part is devoted to a detailed analysis of the case of a system of particles.

8. The eighth part is devoted to a detailed analysis of the case of a system of particles.

9. The ninth part is devoted to a detailed analysis of the case of a system of particles.

10. The tenth part is devoted to a detailed analysis of the case of a system of particles.

11. The eleventh part is devoted to a detailed analysis of the case of a system of particles.

12. The twelfth part is devoted to a detailed analysis of the case of a system of particles.

13. The thirteenth part is devoted to a detailed analysis of the case of a system of particles.

14. The fourteenth part is devoted to a detailed analysis of the case of a system of particles.

15. The fifteenth part is devoted to a detailed analysis of the case of a system of particles.

16. The sixteenth part is devoted to a detailed analysis of the case of a system of particles.

17. The seventeenth part is devoted to a detailed analysis of the case of a system of particles.

18. The eighteenth part is devoted to a detailed analysis of the case of a system of particles.

19. The nineteenth part is devoted to a detailed analysis of the case of a system of particles.

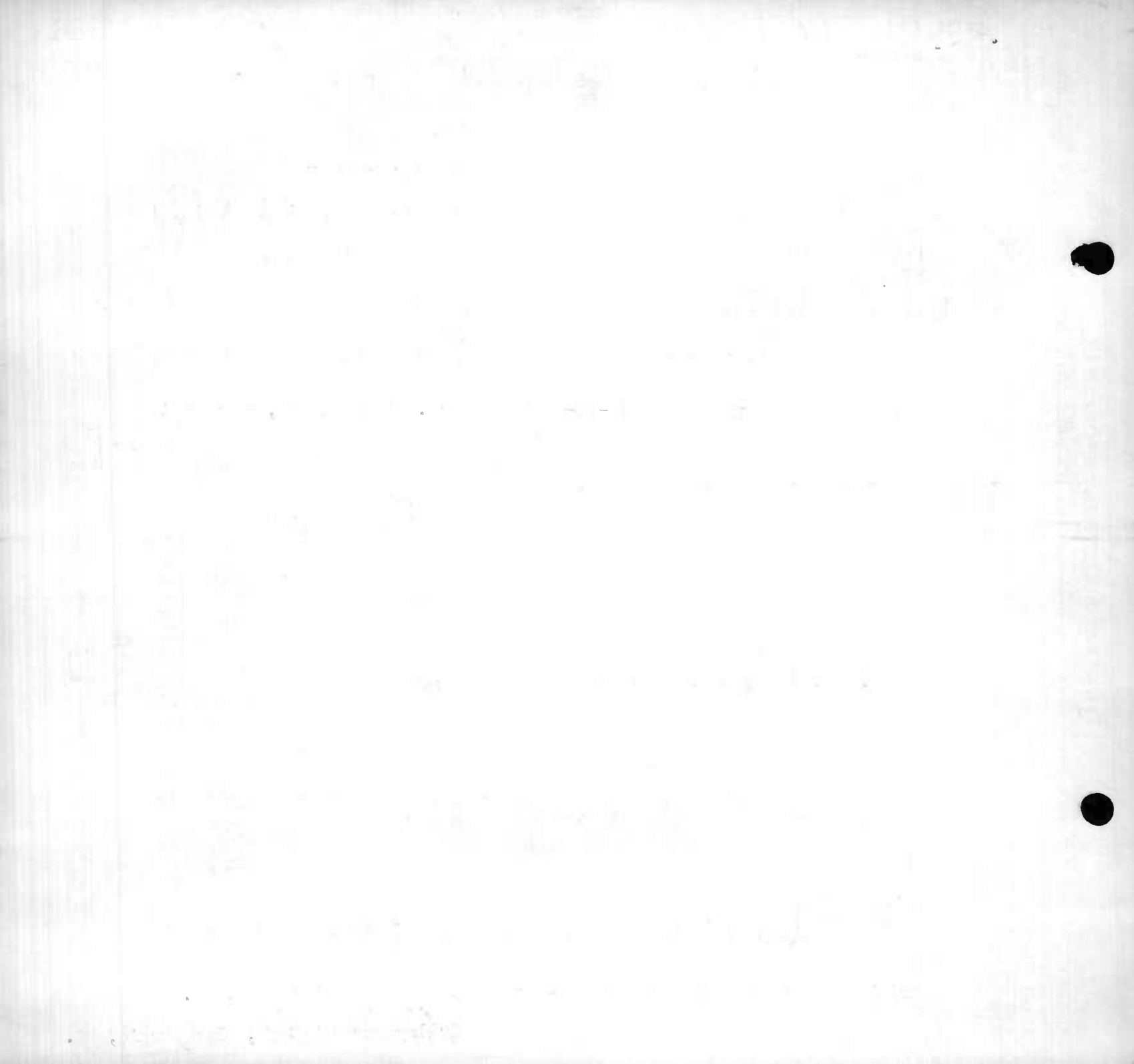
20. The twentieth part is devoted to a detailed analysis of the case of a system of particles.

21. The twenty-first part is devoted to a detailed analysis of the case of a system of particles.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5286					CITY OF BALTIMORE				
M.E. CASE NO.					Registered No. 67 5286				
1. NAME OF DECEASED (Type or Print) <i>Schaub, Philip Sr.</i>					2. DATE AND HOUR OF DEATH <i>5-30-67 12:45 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>U. of Md. Hospital</i>					A. STATE <i>MD</i> B. COUNTY <i>a.g.c.</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>HAROVER</i>				
					D. STREET ADDRESS (If rural, give location) <i>Mulberry Rd. Rt. 1</i>				
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i>	8. DATE OF BIRTH <i>8-28-19</i>	9. AGE (In years last birthday) <i>47</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <i>Real Estate Broker</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>MD.</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George Schaub</i>			14. MOTHER'S MAIDEN NAME <i>Rossana Schaub</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 11</i>			16. SOCIAL SECURITY NO. <i>212-12-6324</i>		17. INFORMANT ADDRESS <i>Mrs. Hilda Schaub, same as 4</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Subarachnoid Hemorrhage</i>					INTERVAL BETWEEN ONSET AND DEATH <i>Thru.</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cerebral Arteriosclerosis</i>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>5-29-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tracheostomy</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>5-29</i> 19 <i>67</i> to <i>5-30</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>5-30</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Law G. L. Brownson</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5-30-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>Law G. L. Brownson</i>					23D. ADDRESS <i>U. of Md. Hospital</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2 June 67</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 1 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Jackson</i>		25C. FUNERAL DIRECTOR <i>Kirkley Funeral Home</i>		ADDRESS <i>Glen Burnie, Md.</i>			



C-140

BIRTH NO. 67 5287		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5287	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) NELLIE May Cofiell COFIELL			2. DATE AND HOUR PRONOUNCED DEAD May 30, 1967 1:19 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL (DOA)			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Balto. Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Reisterstown 53-00 D. STREET ADDRESS (If rural, give location) 926 Lindfellen Avenue		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 2, 1915	9. AGE (In years last birthday) 51	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co.	
13. FATHER'S NAME Reverdy Nash			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215-28-3759		17. INFORMANT ADDRESS Vernon J. Cofiell Reisterstown, Md.
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>422.1 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>Arteriosclerotic Cardiovascular Disease</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> </div> <div style="width: 50%;"> <p>(A) DUE TO</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="width: 50%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21F. HOW DID INJURY OCCUR?		22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/30/67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/2/67		23C. NAME of CEMETERY or CREMATORY Mt. Zion Cemetery	
24A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		24B. NAME OF REGISTRAR Robert E. Taylor, M.D.		24C. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead, Md.	

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11/11/01 BY 60322 UCBAW/STP

[Handwritten signature]

1
G-624

67 5288

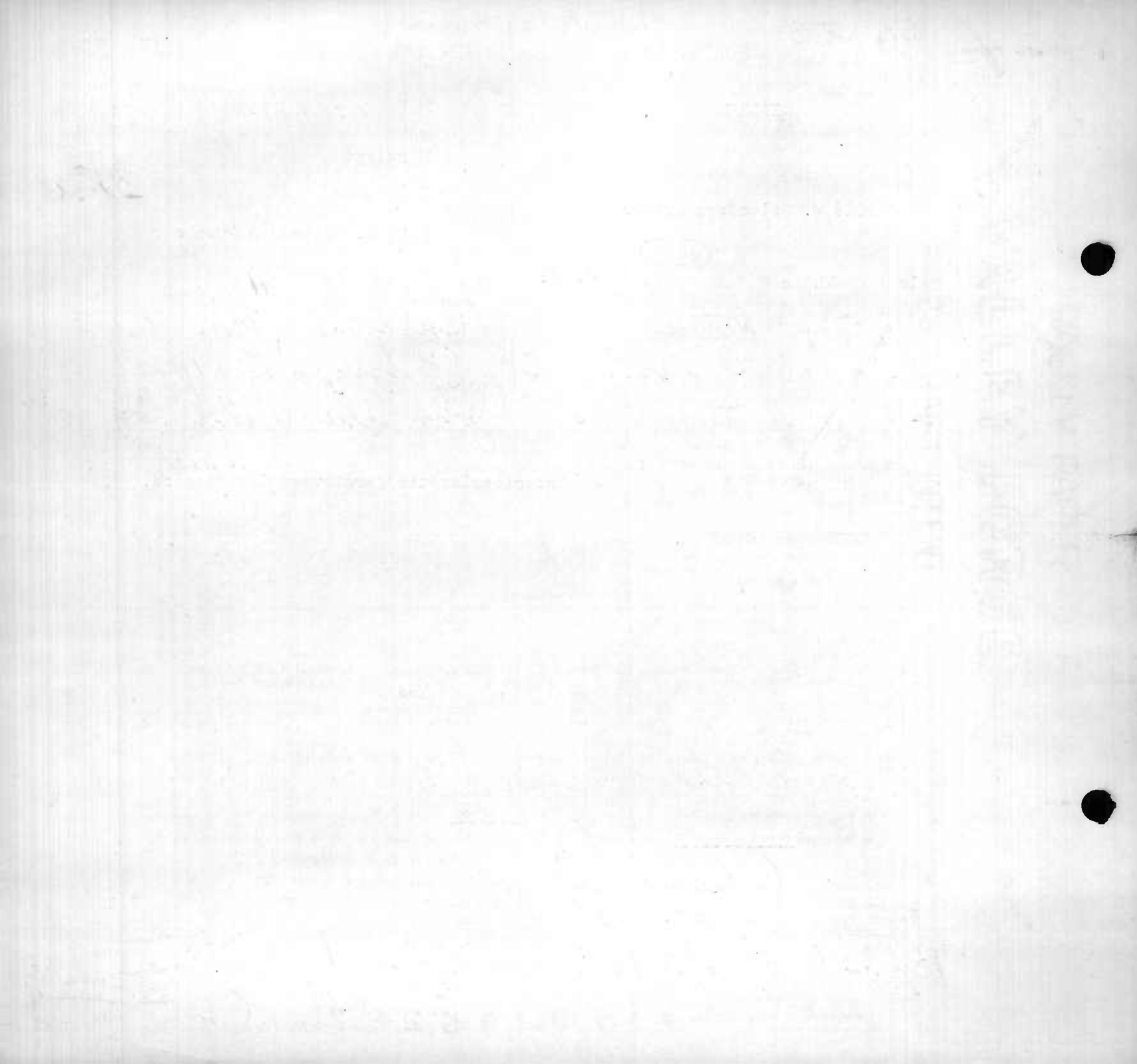
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5288

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print)		WILLIAM H. GRISWOLD		2. DATE AND HOUR PRONOUNCED DEAD May 14, 1967 5:15 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 3626 W. Belvedere Avenue				A. STATE Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-18	
				D. STREET ADDRESS (If rural, give location) 3626 W. Belvedere Avenue	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11/13/18 95	9. AGE (In years last birthday) 77 (71)	If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veteran Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Charles H. Griswold		14. MOTHER'S MAIDEN NAME Patricia L. More.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes. W.W.I.		16. SOCIAL SECURITY NO. yes.		17. INFORMANT John Allen Welch Edgewater Md.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease. DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 5/15/67	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 5/26/67		23C. NAME OF CEMETERY or CREMATORY Baltimore National	
24A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		24B. NAME OF REGISTRAR Philip S. Talbot		24C. FUNERAL DIRECTOR Archibald Funeral Home, Inc.	
		24D. LOCATION (City, town, or county) (State) Baltimore Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5289	
BIRTH NO. 67 5289		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Coppel Benjamin</u>		2. DATE AND HOUR OF DEATH <u>May 27 1967</u> <u>2 50</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>H 2 Sinai Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>3920 Rosecrest Avenue</u>	
5. SEX <u>Male</u>	6. RACE <u>Cauc.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>9/15/76</u>	9. AGE (In years lost birthday) <u>90</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retail Shoes</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-48-1228</u>		17. INFORMANT ADDRESS <u>Mrs. Mary Coppel - 3920 Rosecrest Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction 2 hrs.</u>		CAUSE OF DEATH (A) DUE TO <u>ASCVD.</u> (B) DUE TO <u>Diabetes mellitus</u> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes mellitus</u>			
19A. DATE OF OPERATION <u>May 13 1967</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 13 1967</u> to <u>May 27 1967</u> , that (I) (we) last saw the deceased alive on <u>May 27 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Erwin H. Hesselberg</u> M.D.		23B. DATE SIGNED <u>5/27/67</u>			
23C. PHYSICIAN'S NAME (Type) <u>Erwin H. Hesselberg</u> M.D.		23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/28/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Eden Gresham</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>	
25C. FUNERAL DIRECTOR <u>Dr. [unclear]</u>		25D. ADDRESS <u>600 [unclear] St.</u>			

H-650

67 5290

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5290

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RALPH

HEARN

2. DATE AND HOUR PRONOUNCED DEAD

May 30, 1967

4:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1828 Madison Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

8-11-17

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Hearn

14. MOTHER'S MAIDEN NAME

Ida Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215185451

17. INFORMANT

ADDRESS

Helen Dixon 1728 Ashburton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~XXXXXX~~Bronchopneumonia complicating cranio-
cerebral injury

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5/27/67 about 4:30 P.M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

presumably fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/30/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-2-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Balto.

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 1 1967

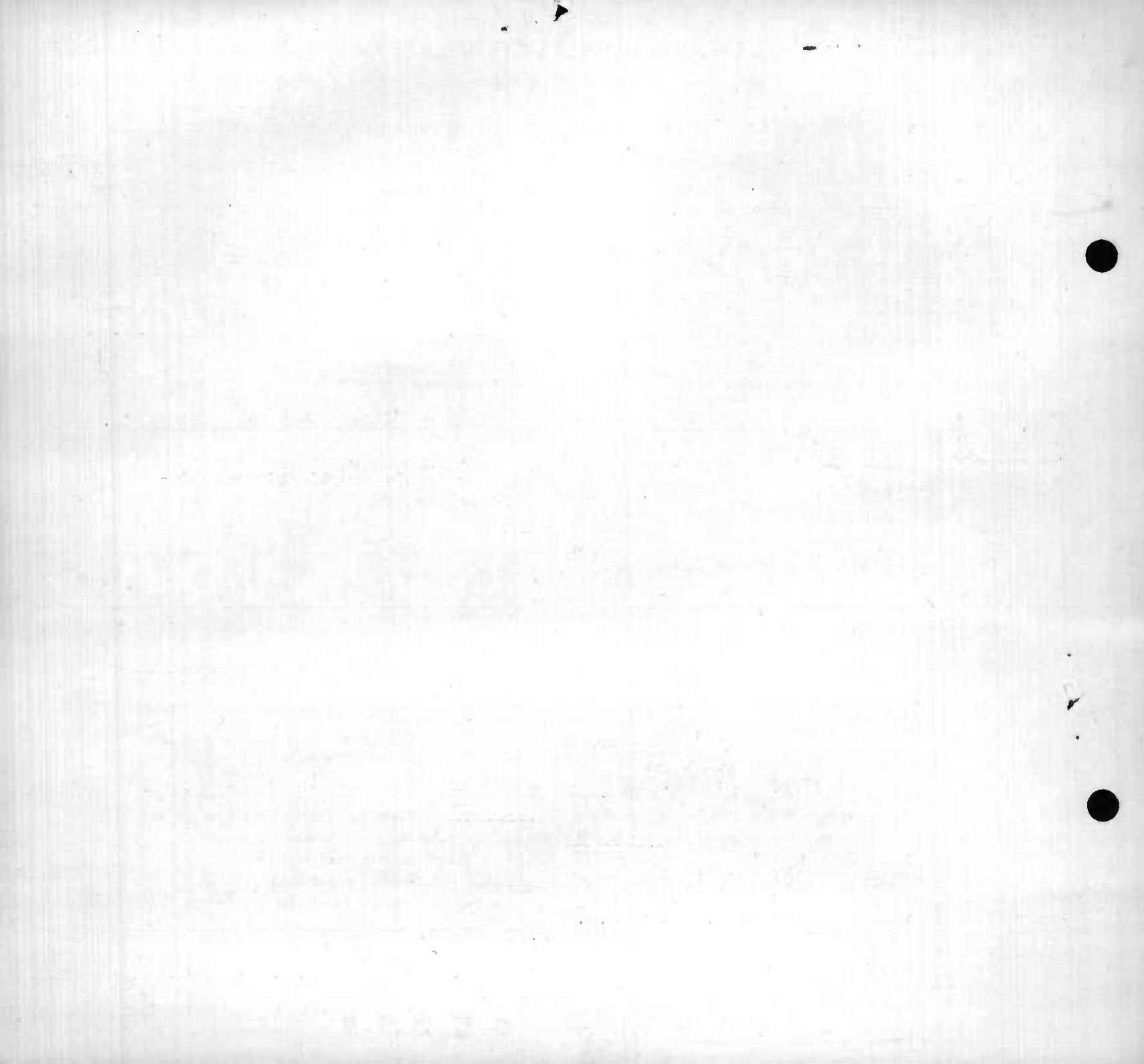
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5291</u>	
BIRTH NO. <u>67 5291</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES YOUNG</u>		2. DATE AND HOUR OF DEATH <u>5-29-1967</u> <u>2.00 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hospital</u>		A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u>		D. STREET ADDRESS (If rural, give location) <u>2747 W. North Ave.</u>			
5. SEX <u>m</u>	6. RACE <u>negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>4-27-21</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>American</u>
13. FATHER'S NAME <u>Charles Young</u>			14. MOTHER'S MAIDEN NAME <u>Mary</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ophelia Young</u> <u>2747 W. North Ave.</u>	
18. <u>592X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>central hemorrhage</u>		CAUSE OF DEATH (A) DUE TO <u>Chronic glomerulonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>many years</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>5-29</u> 19 <u>67</u> to <u>5-29</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>5-29, 2.00 PM</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Pyang Il Kwon</u> M.D.				23B. DATE SIGNED <u>5-29-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>PYOUNG IL KWON</u> M.D.				23D. ADDRESS <u>SINAI Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-1-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Kelson</u>		25C. FUNERAL DIRECTOR <u>Kelson</u>	
		ADDRESS <u>Kelson Funeral Home 1348 Calhoun St.</u>			

2-2-51

SMAL

81241 110 12 1/2

4-5-51 +6

in Judge named

Ames

Order brought
Chick from the

2-5-51

2-5-51
2-5-51

○

2-5-51

Good of know

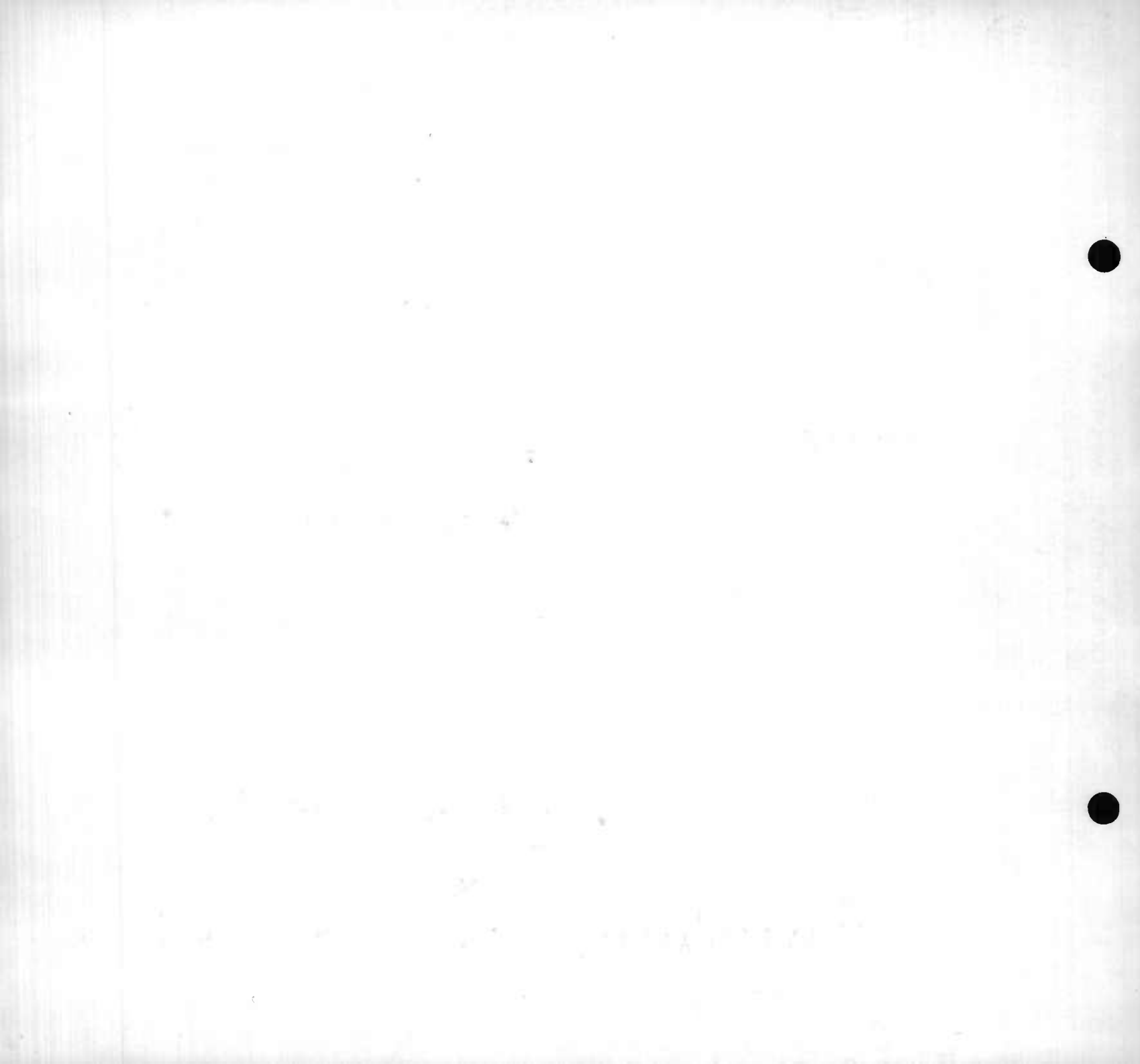
High 124

2544

Know 12 know

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

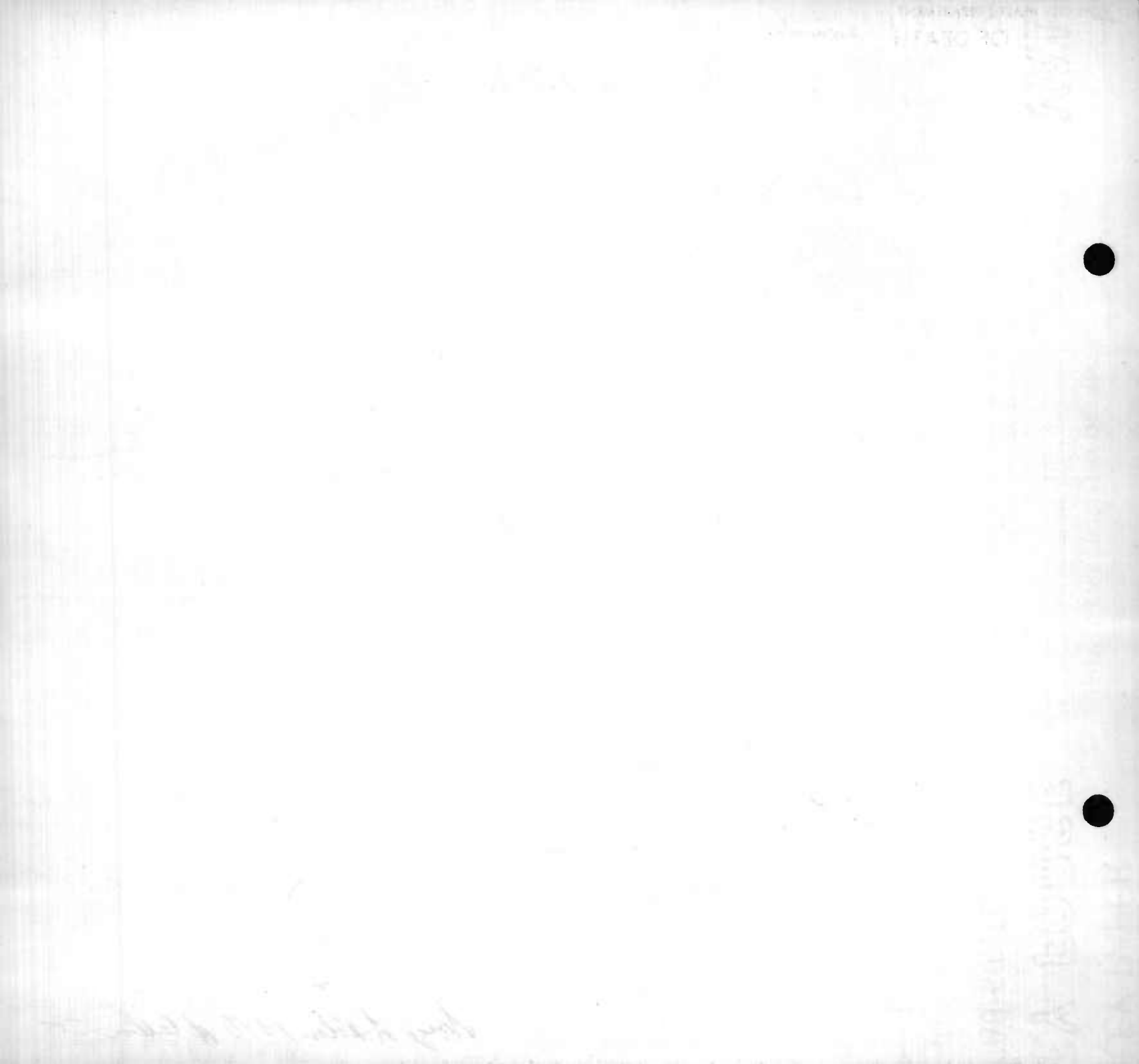
BIRTH NO. 67 5292				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5292	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Annie Stewart		5-29-67 1 2 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Md.		B. COUNTY	
00 1657 Bakebury Court				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Balto. 75-02	
D. STREET ADDRESS (If rural, give location)				1657 Bakebury Court			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
Female	Negroid	widowed	10-9-98	68			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Va.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joe Henderson				Liza Pagan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
		218229603		Corine Coleman		836 Whitmore Ave.	
18. 431.41 CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO		5-23-66 - 5-24-67	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				C. Pulverular disease of heart			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Arterio sclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
Cerebral accident							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 5-23-67 to 5-29-67, that (I) (we) last saw the deceased alive on 5-19-67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John E. T. Camper				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN E. T. CAMPER				M.D. 639 N. Grey St., Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-2-67		Arbutus Mem. Pk.		Arbutus, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 1 1967		John E. T. Camper		Kelson Funeral Home		1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

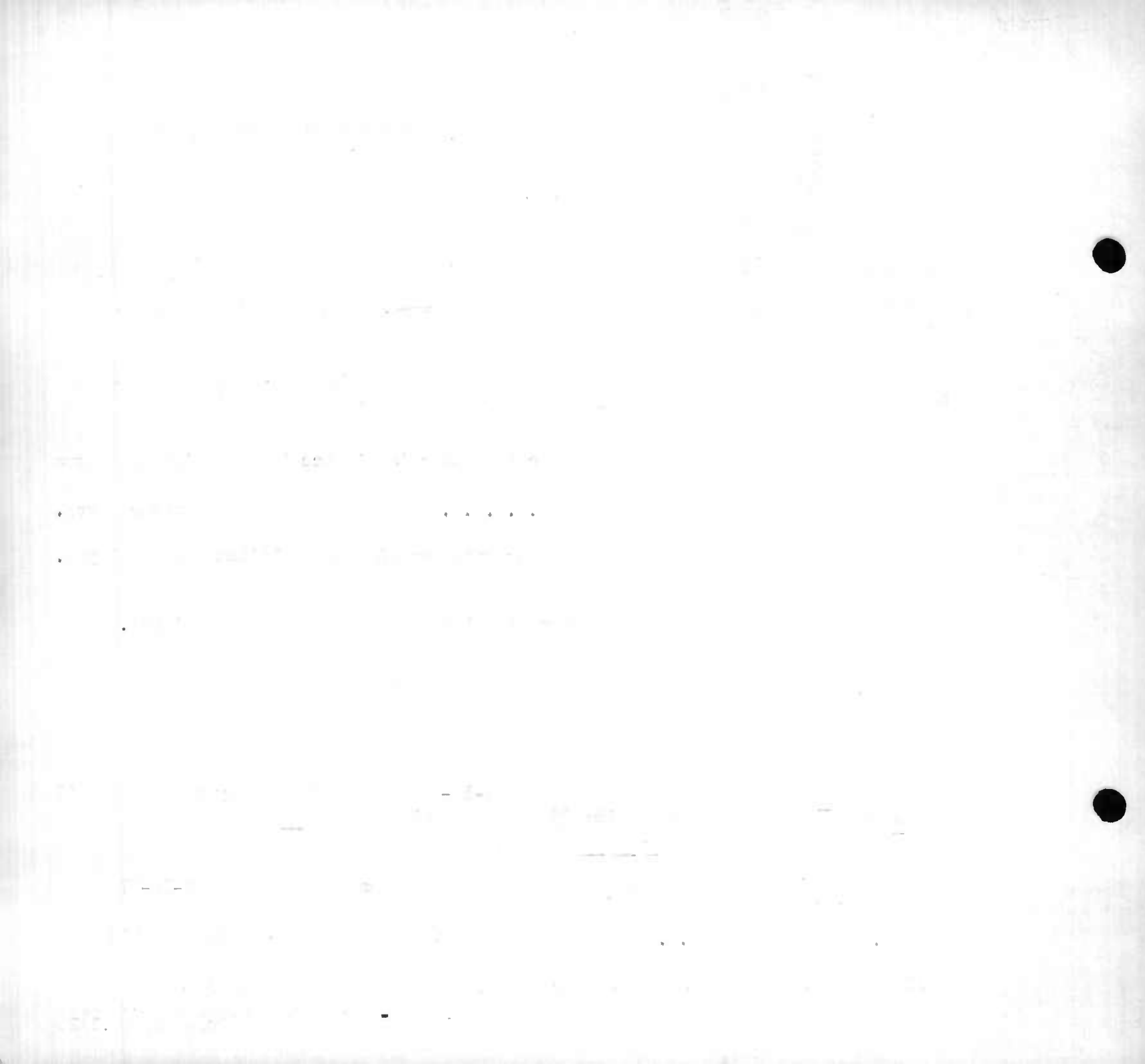
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>67 5293</u>				
BIRTH NO. <u>67 5293</u>									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>TOYER, NATHANIEL</u>					2. DATE AND HOUR OF DEATH <u>5/30/67</u> <u>1:15 P</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital of Maryland</u> (If not in hospital or institution, give street address or location)					A. STATE <u>MD.</u> B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>1707 Dukeland Street</u>				
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>		8. DATE OF BIRTH <u>5/22/21</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>John Toyer</u>					14. MOTHER'S MAIDEN NAME <u>Mary</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>218148055</u>		17. INFORMANT ADDRESS <u>Mary Toyer 1707 Dukeland St.</u>				
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>C.V.A. cerebrovascular accident</u> DUE TO (B) <u>H.A.S.D.</u> DUE TO (C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <u>the</u> (this hospital) attended the deceased from <u>5/29/67</u> to <u>5/30/67</u> that (I) <u>we</u> last saw the deceased alive on <u>5/30/67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (We) (did not) view the body after death.									
23A. SIGNATURE <u>I. Regaie</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/30/67</u>		
23C. PHYSICIAN'S NAME (Type) <u>IRAJ REJAIE</u>					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-3-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Stacy A. Kuler</u>		ADDRESS <u>1348 N. Calhoun St</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 3567 5294	
BIRTH NO. 67 5294		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Hill, Goldie		2. DATE AND HOUR OF DEATH May 30, 1967 12:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Nursing & Convalescent Ctr.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 263 Ridge Avenue			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 30, 1889	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10B. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nicholas Paull			14. MOTHER'S MAIDEN NAME Carrie Berger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-07-5039	17. INFORMANT Jessie Hill, 290 Nottingham Hill, Sherwood Forest, Md, 21405		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) acute myocardial infarction		CAUSE OF DEATH (A) DUE TO A.S.C.V.D. (B) DUE TO aggravated by diabetes mellitus (C)		INTERVAL BETWEEN ONSET AND DEATH instantaneous several yrs. several yrs.	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II Hypertension		1 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) no	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4-17- 19 66 to May 30 19 67 , that (I) (we) last saw the deceased alive on May 29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook M.O.				23B. DATE SIGNED 5-30-67	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK M.D.			23D. ADDRESS 2421 Maryland Ave. BALTO 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE June 1, 1967	24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR Wm. Cook-Brooks	25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204		



C-450

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 67 5295		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5295	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) GLADYS CALLAHAN		2. DATE AND HOUR PRONOUNCED DEAD May 30 1967 105 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 003718 Fairhaven Road XXXXXXXX		A. STATE Baltimore Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-05 D. STREET ADDRESS (If rural, give location) 3718 Fairhaven Rd	
5. SEX Fem	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 6, 1908
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 58
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Lloyd		14. MOTHER'S MAIDEN NAME Gladys ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT John Callahan		ADDRESS 37.8 Fairhaven Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic Cardio-Vascular Disease.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5.30.67 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/2/67	
23C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		23D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	
24C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.		ADDRESS 1217 St. Paul St.	

Page 2

1977-1978

Page 3

1977-1978

Page 4

1977-1978

Page 5

1977-1978

Page 6

Page 7

Page 8

1977-1978

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 67 5296					
BIRTH NO. 67 5296					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Esther E. Jackson</i>					2. DATE AND HOUR OF DEATH <i>5-30-67 13⁵⁰ P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(If not in hospital or institution, give street address or location)			A. STATE <i>MD</i>		B. COUNTY			
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO. 15-04</i>					
					D. STREET ADDRESS (If rural, give location) <i>2004 MC KEAN AVE</i>					
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOW</i>		8. DATE OF BIRTH <i>6/7/03</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>George Holmes</i>				14. MOTHER'S MAIDEN NAME <i>ANNIE E. THOMAS</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Esther Jeffries 1914 Donald Hill Ave</i>				
18. <i>330X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Brain stem compression</i> DUE TO (B) <i>Subarachnoid hemorrhage</i> DUE TO (C) <i>Relational int. cerebral aneurysm</i>			INTERVAL BETWEEN ONSET AND DEATH <i>12 hr.</i> <i>48 hr.</i> <i>(?)</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>5/28/67</i> 19 to <i>5/30</i> 1967, that (I) (we) last saw the deceased alive on <i>5/30</i> 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Ronald H. Paul</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/31/67</i>			
23C. PHYSICIAN'S NAME (Type) <i>RONALD L. PAUL</i>					23D. ADDRESS <i>MERCY HOSPITAL, BALTO., MD</i>					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>6/3/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MT. AUBURN</i>			24D. LOCATION (City, town, or county) (State) <i>BALTO. MD</i>			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR <i>John E. Thomas</i>			25C. FUNERAL DIRECTOR <i>Joseph J. 13047 Central Ave</i>			ADDRESS	

From the 1st of January
to the 31st of December
1892

1892

1892

1892

1892

1892

1892

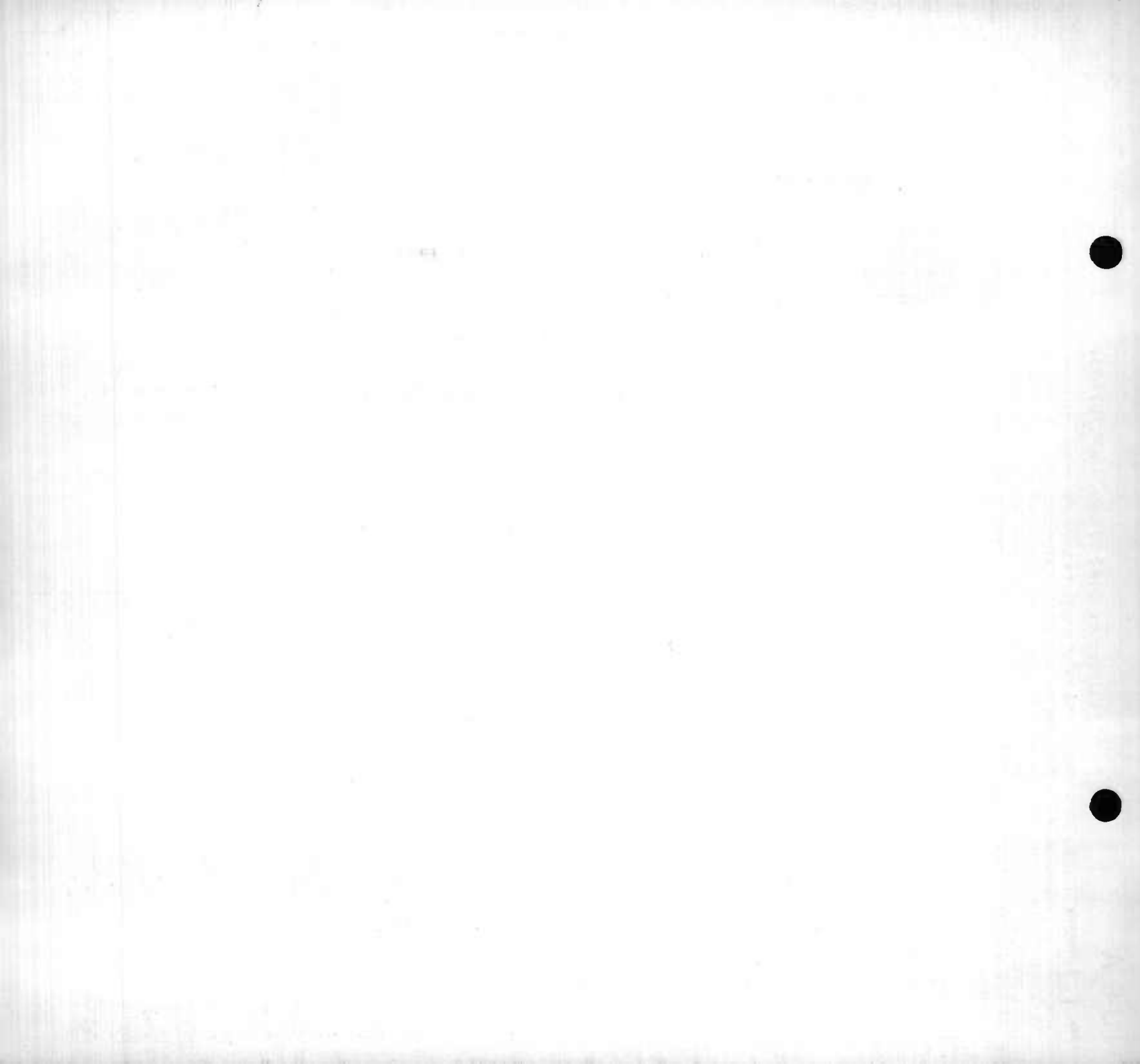
1892

1892

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

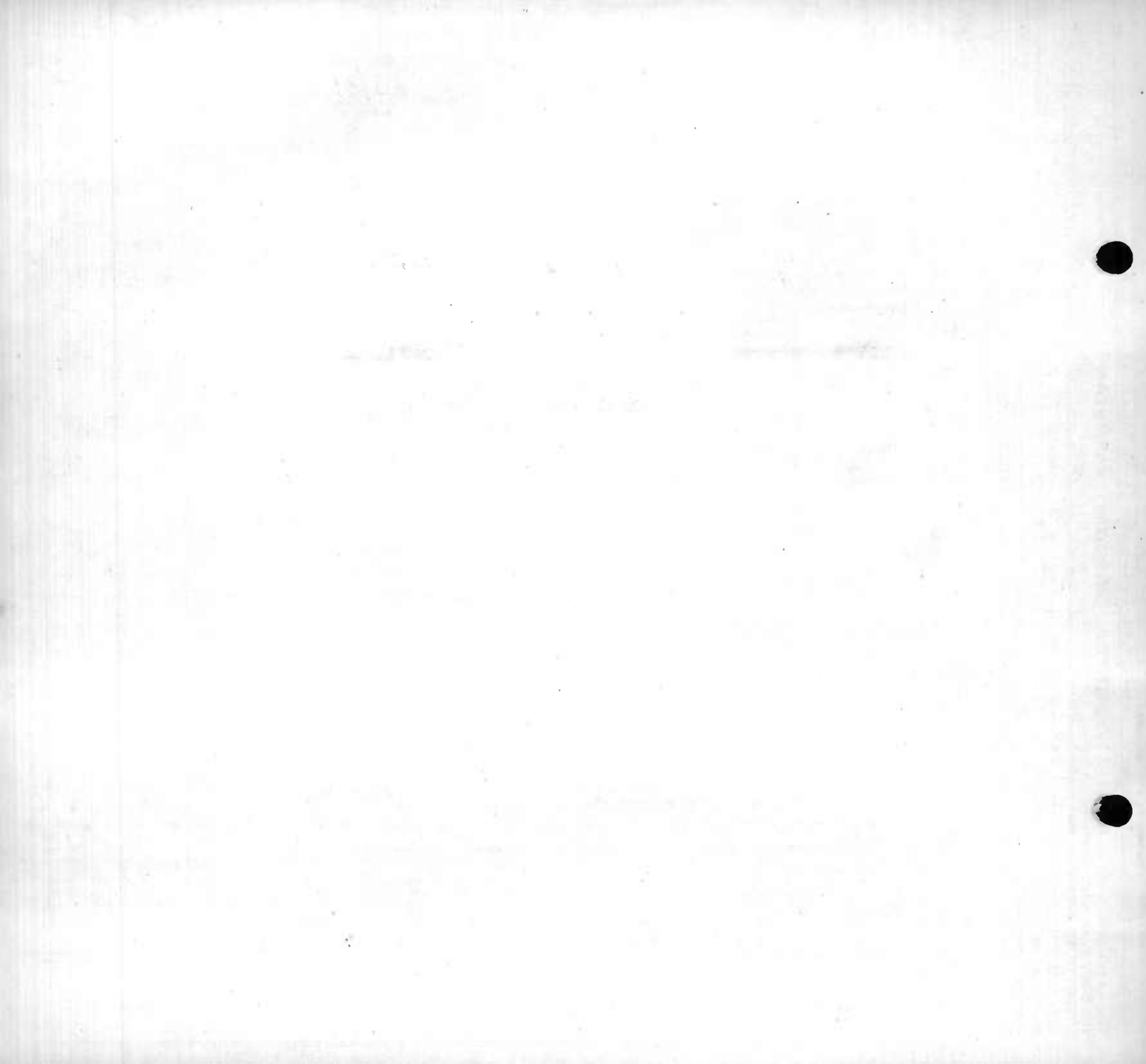
BIRTH NO. 67 5297				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5297	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FRANK BYNUM				2. DATE AND HOUR OF DEATH 5/29/67 12:00 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL BAYVIEW 16, MD.		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 1524 Poplar Grove Street			
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 6-15-1900	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Town Creek, Ala.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emmett Bynum				14. MOTHER'S MAIDEN NAME Mary ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-03-7755A		17. INFORMANT ADDRESS Mrs. Viola Bynum 1524 Poplar Grove St. 21216			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Carcinoma of Penis with metastasis. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Angel H. Roque M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/29/67	
23C. PHYSICIAN'S NAME (Type) ANGEL H. ROQUE M.D.				23D. ADDRESS LUTHERAN HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-4-67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS 1735 Harford Avenue Marshall W. Jones Jr. Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

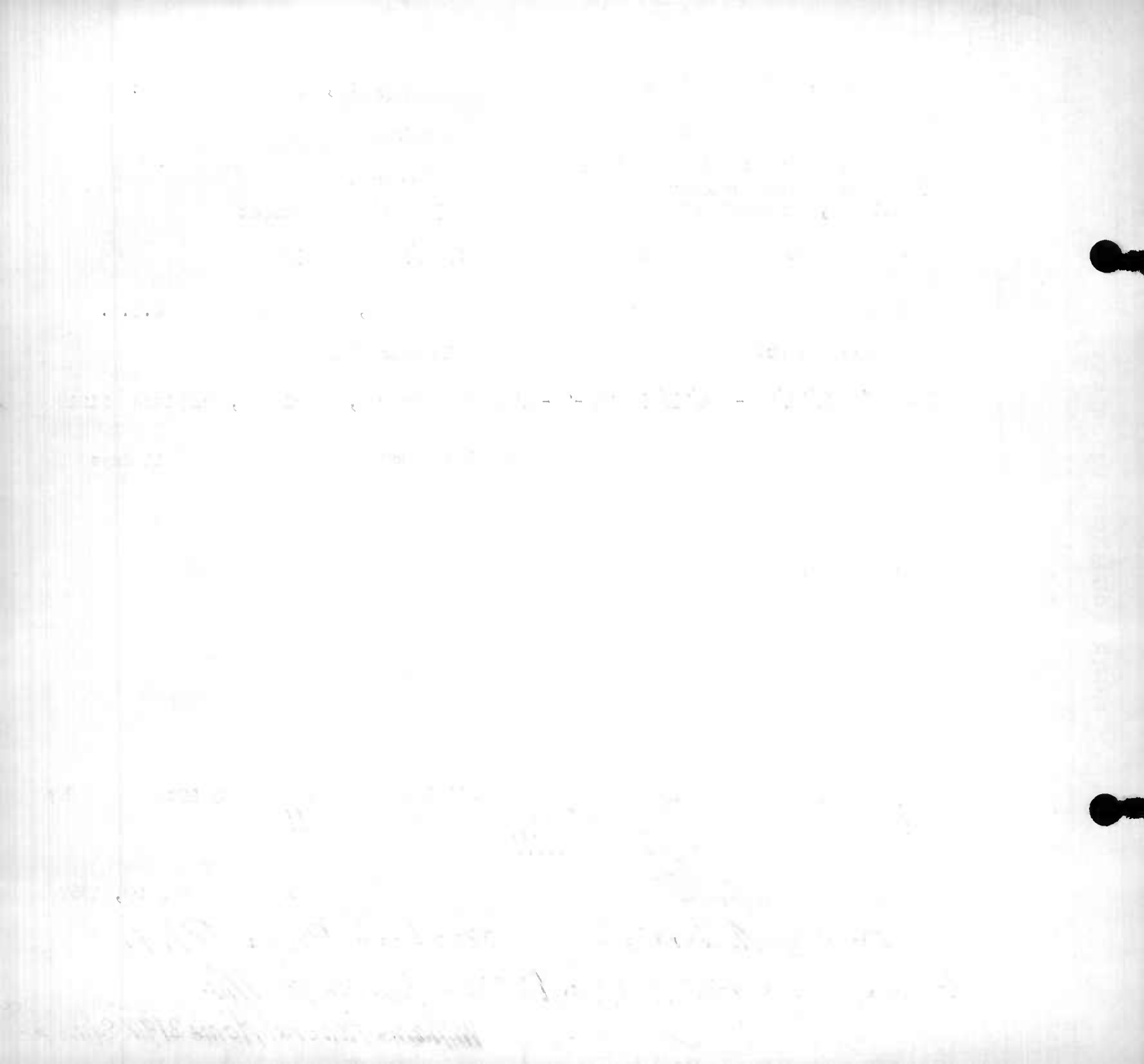
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5298	
BIRTH NO. 67 5298		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAHEL CARTER		2. DATE AND HOUR OF DEATH 5/30/67 4:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1605			
FULL NAME OF HOSPITAL OR INSTITUTION 2515 Harlem Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 2516 Harlem ave.			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH June 16, 1910	9. AGE (In years last birthday) 56	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10B. KIND OF BUSINESS OR INDUSTRY Md. Casualty Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME William Brown		14. MOTHER'S MAIDEN NAME Carrie ? ?		12. CITIZEN OF WHAT COUNTRY? U.S.A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-14-3336		17. INFORMANT CHART - OFFICE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Adenocarcinoma of 6 all bladder (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH 18 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/22/66		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydric obstruction		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5/30 19 66 to 5/30 19 67 and that (1) (we) last saw the deceased alive on 5/30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elizah Saunders		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/31/67	
23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS		23D. ADDRESS 3414 Duwall ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/3/67		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR R. E. E. Taylor		25C. FUNERAL DIRECTOR Herbert O. Vutter	
				ADDRESS -3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5299	
BIRTH NO. 67 5299		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) McNUTT, GILBERT GRIFFIN		2. DATE AND HOUR OF DEATH May 29, 1967 1:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		5. SEX	
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital		A. STATE Maryland		Male	
ADDRESS 3900 Loch Raven Boulevard		B. COUNTY Baltimore		Negro	
Baltimore, Maryland 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced	
D. STREET ADDRESS (If rural, give location) 813 N Dukeland Street		8. DATE OF BIRTH 2/14/32		9. AGE (In years last birthday) 35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Lawrence McNutt		14. MOTHER'S MAIDEN NAME Florence Holden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12/15/50 - 11/23/53		16. SOCIAL SECURITY NO. 215-28-1504		17. INFORMANT ADDRESS VAH Records, Baltimore, Maryland 21218	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac Arrest		11 days			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 17th 1967 to May 29th 1967 , that (I) (we) last saw the deceased alive on May 29th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Domingo A. Garcia		23B. DATE SIGNED May 29, 1967	
23C. PHYSICIAN'S NAME (Type) Domingo A. Garcia		23D. ADDRESS 3900 Loch Raven Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/2/1967		24C. NAME OF CEMETERY or CREMATORY Balto. National Cem. Balto. Md.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR William T. Talbot	
25C. FUNERAL DIRECTOR William T. Talbot		25D. ADDRESS 319 N. Schneider St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5300</u>	
BIRTH NO. <u>67 5300</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>MARY E. HUNT</u>		2. DATE AND HOUR OF DEATH <u>MAY 29, 1967</u> <u>1 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTO.</u>		A. STATE <u>MD.</u> B. COUNTY <u>X</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>4-02</u>			
		D. STREET ADDRESS (If rural, give location) <u>221 N. FREMONT</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SEPARATED</u>	8. DATE OF BIRTH <u>9/1/33</u>	9. AGE (In years lost birthday) <u>33</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samore Jones</u>			
14. MOTHER'S MAIDEN NAME <u>Beulah Garrett Smith</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-26-4822</u>		17. INFORMANT ADDRESS <u>Beulah Smith 221 N. Fremont Ave.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>RENAL FAILURE</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CHRONIC RENAL DISEASE</u> DUE TO		MANY YEARS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>DIABETES MELLITUS</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (This hospital) attended the deceased from <u>MAY 2</u> 19 <u>67</u> to <u>MAY 29</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAY 29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Melvyn B. Lewis</u>				23B. DATE SIGNED <u>MAY 29, 1967</u>	
23C. PHYSICIAN'S NAME (Type) <u>MELVYN B. LEWIS</u>		23D. ADDRESS M.D. <u>SINAI HOSPITAL OF BALTO.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/3/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>	
24D. LOCATION <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 1 1967</u>		25B. NAME OF REGISTRAR <u>Dr. E. E. Feltz, MD</u>	
25C. FUNERAL DIRECTOR <u>William J. Farnham</u>		25D. ADDRESS <u>Home 31</u>			

38

18. 10. 1944. 10. 10. 1944.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 5301					CERTIFICATE OF DEATH					Registered No. 67 5301				
1. NAME OF DECEASED (Type or Print) Wilson Williams					2. DATE AND HOUR OF DEATH 5/31/67 130 p.m.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND THE JOHNS HOPKINS HOSPITAL 33					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 8-07 D. STREET ADDRESS (If rural, give location) 1400 NORTH BETHEL STREET									
5. SEX MALE		6. RACE NEGRO		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED		8. DATE OF BIRTH 2-2-02		9. AGE (In years last birthday) 65		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Md.				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME STEPHEN WILLIAMS					14. MOTHER'S MAIDEN NAME CARRIE BURGESS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Benjamin Williams ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 162.71 BRONCHOGENIC CA POSSIBLE GRAM NEGATIVE SEPSIS HEMOLYTIC ANEMIA HYPERKALEMIA					19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					20. INTERVAL BETWEEN ONSET AND DEATH				
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from (we) last saw the deceased alive on (We) (did) view the body after death.					23A. SIGNATURE SW Spaulding M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 5/31/1967				
23C. PHYSICIAN'S NAME (Type) STEPHEN W. SPAULDING					23D. ADDRESS THE JOHNS HOPKINS HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE Jun 5/67					24C. NAME OF CEMETERY OR CREMATORY Mt. Greenway Cem				
24D. LOCATION (City, town, or county) (State) A.A. County Md					25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967					25B. NAME OF REGISTRAR R. E. Edwards				
25C. FUNERAL DIRECTOR 1129 N. ...					25D. ADDRESS ...									

Brachodermis (A)
Locate from negative copies
Hemaphysalis
Hypodermis

No

Yes

2/21

2/21

2/21

2/21
mean

2W Spaulding

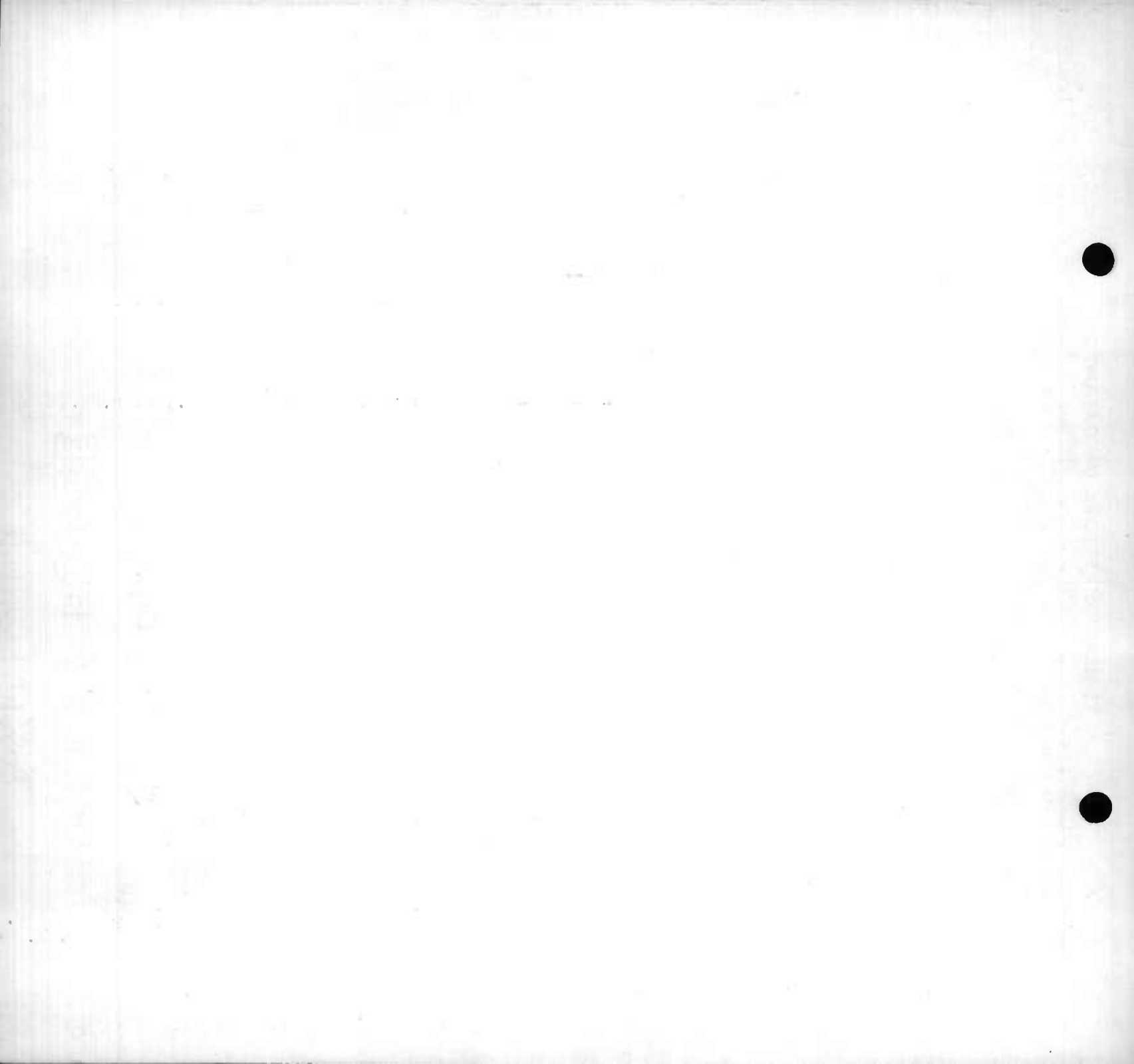
x

2/21/1954

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

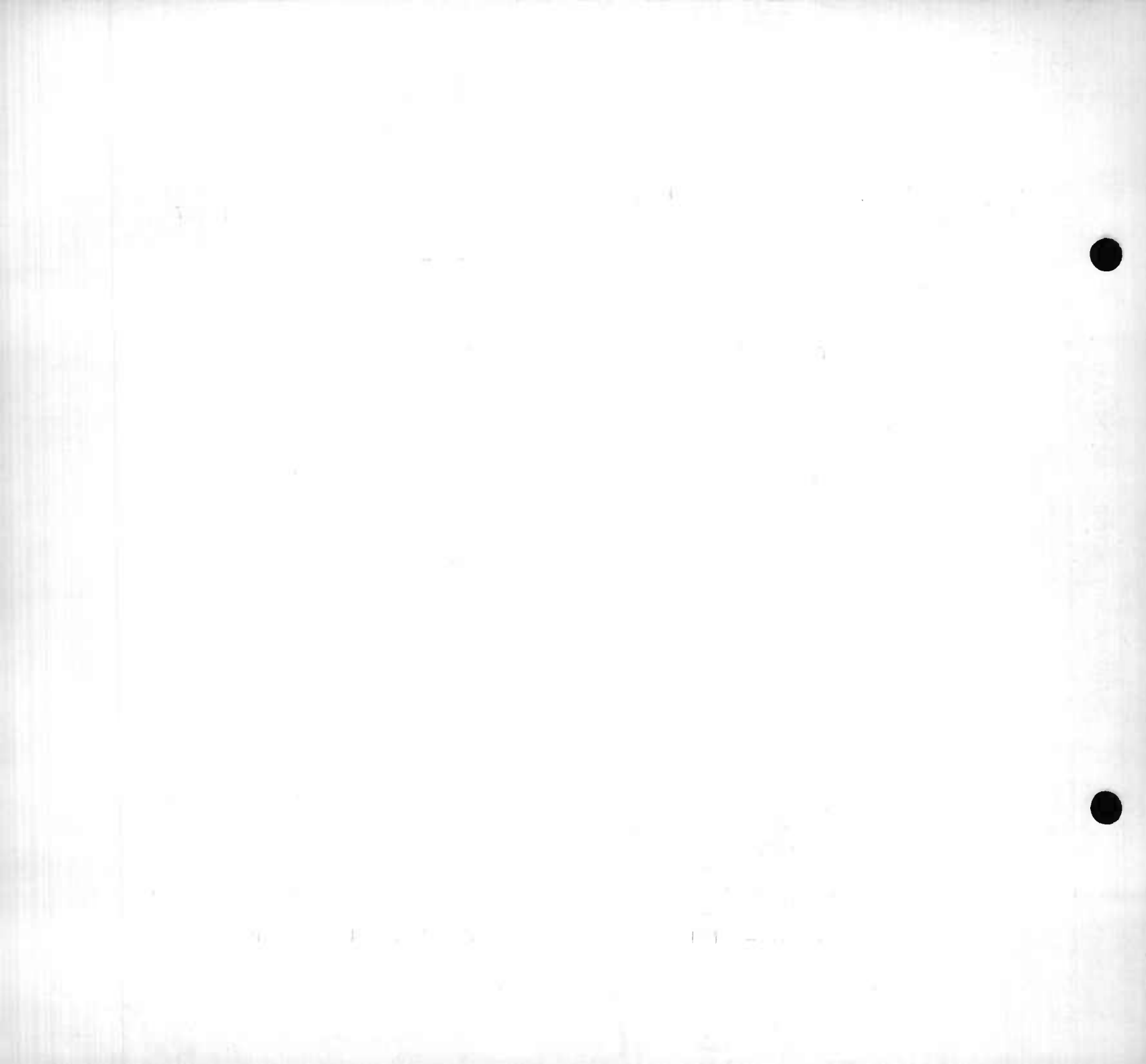
BIRTH NO. 67 5302				BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		Registered No. 67 5302	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) WILLIAM TAYLOR				2. DATE AND HOUR OF DEATH 5/31/67 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				8-06	
				D. STREET ADDRESS (If rural, give location) 1536 N. BOND STREET - 21213					
5. SEX Male	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3/24/90	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HENRY TAYLOR				14. MOTHER'S MAIDEN NAME MARTHA SCARLIN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-4215-A		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224					
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) BRONCHOGENIC CA DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/12 19 67 to 5/31 19 67, that (I) (we) last saw the deceased alive on 5/31 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jan Shank				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/31/67			
23C. PHYSICIAN'S NAME (Type) IAN SHENK				M.D.		23D. ADDRESS BALTIMORE CITY HOSPITALS, 4940 Eastern Ave. 550 N. BROADWAY AVE. BALTO., MD. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jun 4/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION A. County Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967		25B. NAME OF REGISTRAR R. E. Jackson		25C. FUNERAL DIRECTOR Barton E. Elshorn		ADDRESS 1129 N. Charles St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

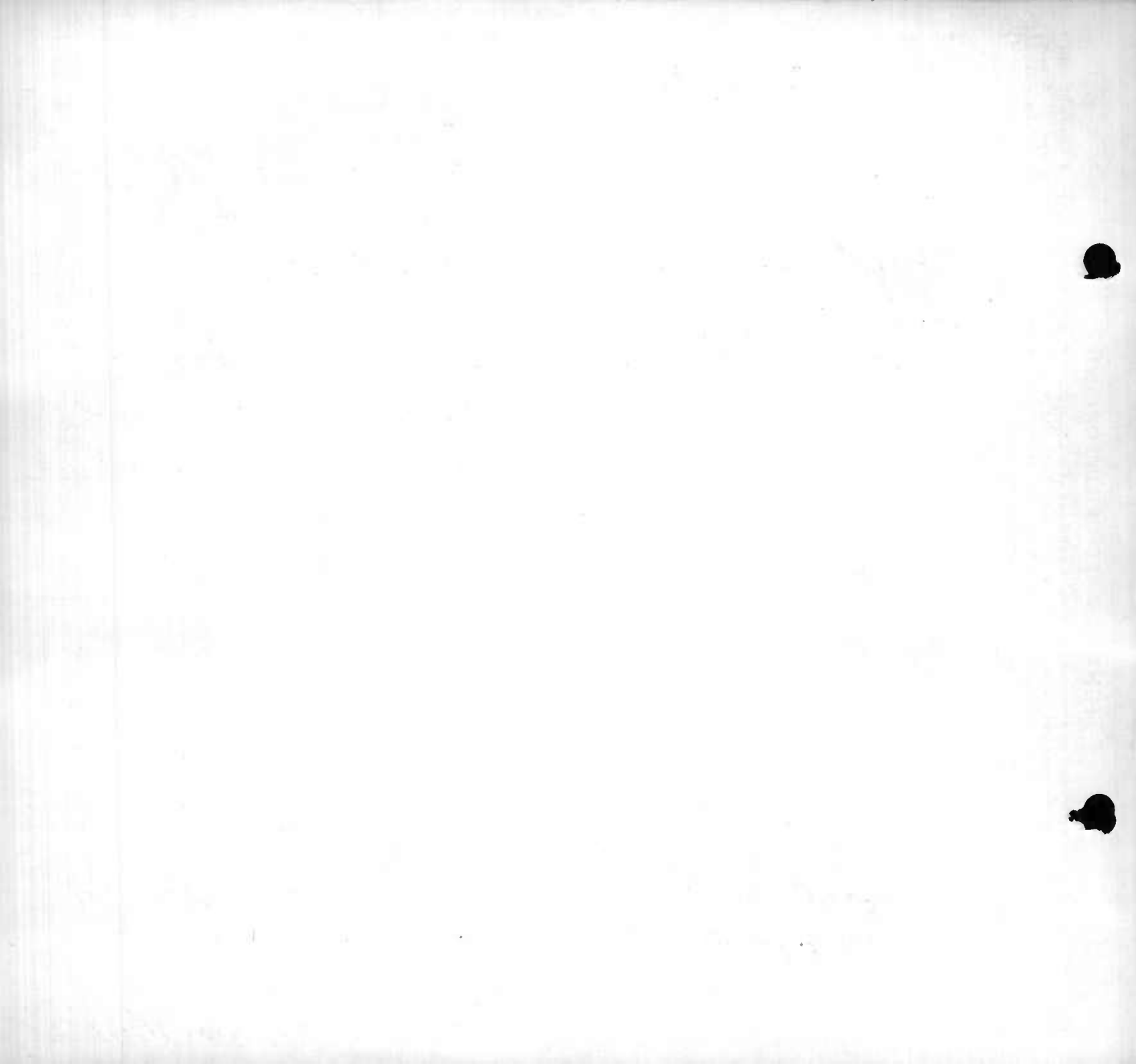
BIRTH NO. 67 5303		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5303	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROSCOE LOTT			2. DATE AND HOUR OF DEATH 10 15 AM May 25 67 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2635 EAST CHASE STREET		
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3-28-25	9. AGE (In years lost birthday) 42	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME EDWARD LOTT			14. MOTHER'S MAIDEN NAME FRANCES BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Lue Bertha Lott		ADDRESS
18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cadaveric arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Uremia hypertension			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 5/25		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/25 19 67 to 5/25 19 67 , that (I) (we) last saw the deceased alive on 5/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Ismael Beigi				23B. DATE SIGNED 5/25/67	
23C. PHYSICIAN'S NAME (Type) FARAMARZ ISMAIL-BEIGI		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 29/67		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem	
24D. LOCATION (City, town, or county) (State) A.A. County Md		25A. DATE REC'D BY HEALTH DEPT. JUN 1 1967			
25B. NAME OF REGISTRAR Robert E. Clarke		25C. FUNERAL DIRECTOR Matthew E. Ellickson 1129 N. Calhoun St			



FUNERAL DIRECTOR: IMPORTANT

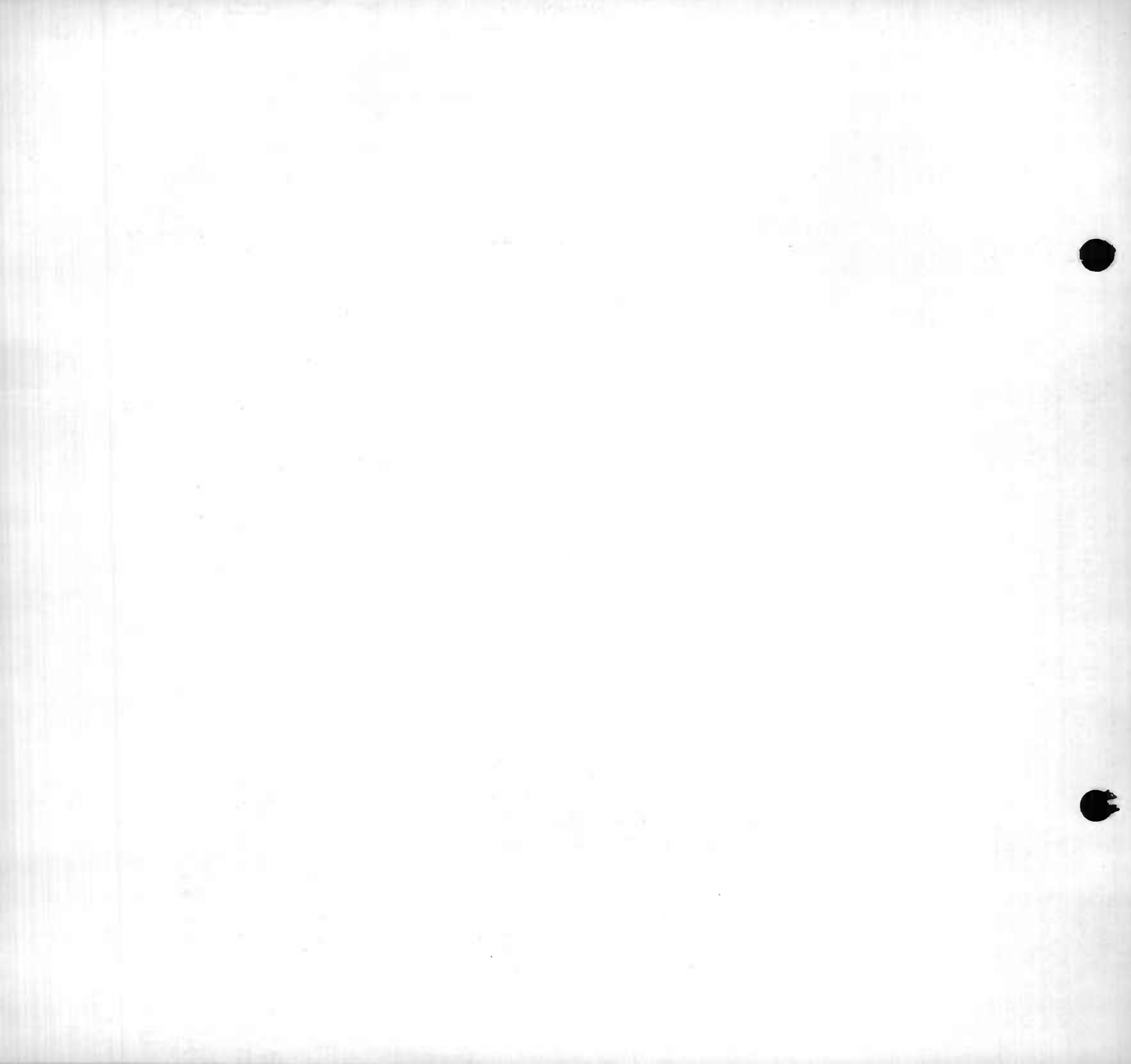
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO.		67 5304		Registered No.		67 5304					
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
				<i>OLIVER HALL</i>				<i>11:30 pm 5-30-67</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND								4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i>								A. STATE <i>Maryland</i>			
								B. COUNTY			
								C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
								D. STREET ADDRESS (If rural, give location) <i>912 Gay St.</i>			
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Mar.</i>		8. DATE OF BIRTH <i>9/27/1915</i>		9. AGE (In years last birthday) <i>61</i>		10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Hall</i>				14. MOTHER'S MAIDEN NAME <i>Henriette Barnes</i>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Marjorie Wiley 1251 Augusta Ave.</i>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>153.81</i>								CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.								(A) DUE TO <i>Acute Renal Failure, Sepsis, hypokalemia 24hrs.</i>			
								(B) DUE TO <i>Intestinal Obstruction, 48 hrs. 1 wk</i>			
								(C) DUE TO <i>Metastatic Carcinoma of Colon 6 mo - 2 yrs</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>5-27-67</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction</i>				20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that he (this hospital) attended the deceased from <i>5-21-</i> 19 <i>67</i> to <i>5-30</i> 19 <i>67</i> , that he (we) last saw the deceased alive on <i>5-30</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Arthur C. Burdett</i>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5-30-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ARTHUR C. BURDETT</i>								23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>June 3/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cem</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. Counties Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 1 1967</i>				25B. NAME OF REGISTRAR <i>R. E. E. Edwards</i>				25C. FUNERAL DIRECTOR ADDRESS <i>Milton E. Edickson 1129 N. Calver St.</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

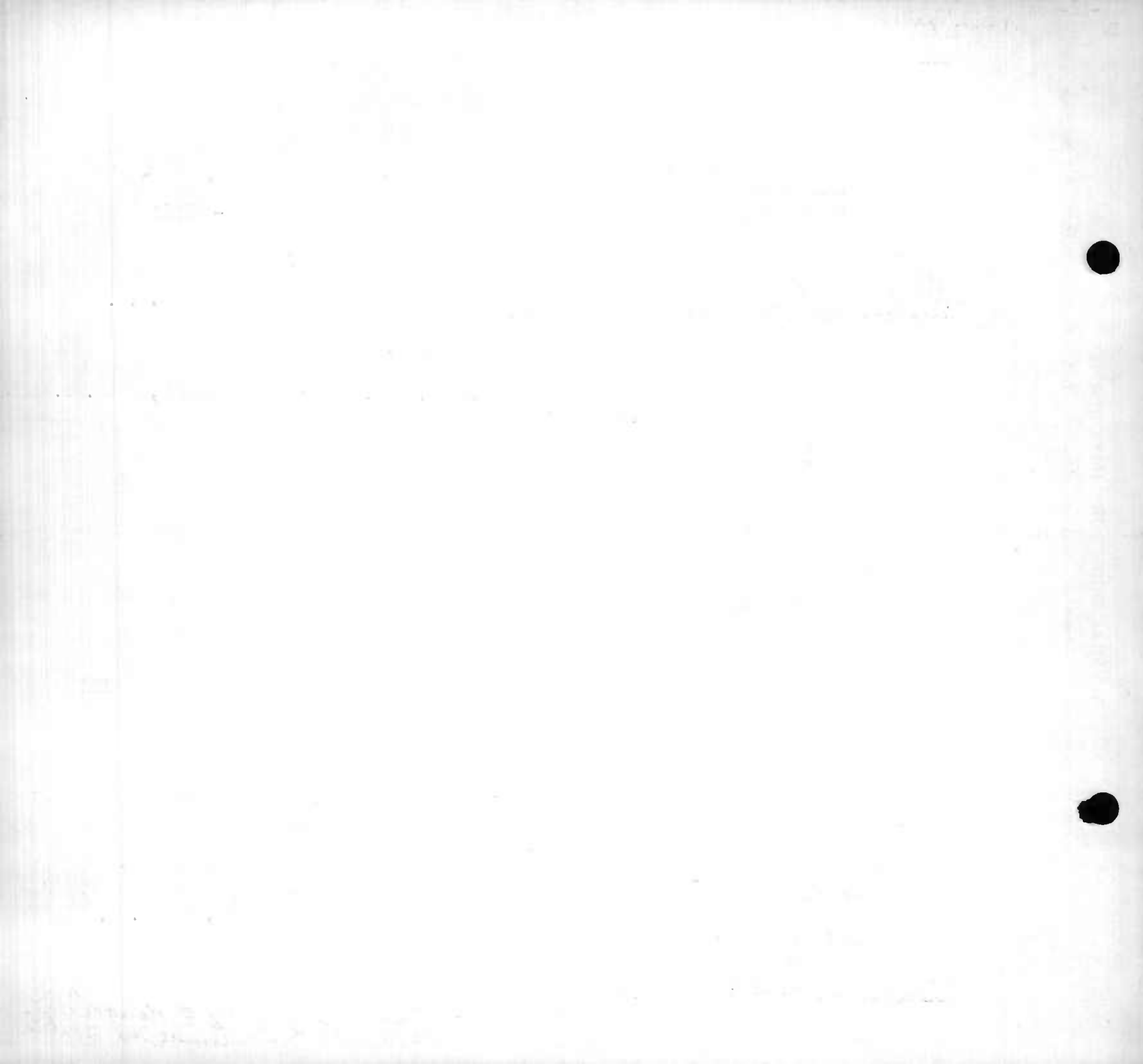
BALTIMORE CITY HEALTH DEPARTMENT									
67 5305					Registered No. 67 5305				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Mary Morris Allen</i>					2. DATE AND HOUR OF DEATH <i>May 29/67</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (When deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 1205 N. Caroline St</i>					A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>1205 N. Caroline St</i>				
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Jan. 5, 1892</i>	9. AGE (In years last birthday) <i>75</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Charlottesville Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>?</i>
13. FATHER'S NAME <i>James Houtard</i>			14. MOTHER'S MAIDEN NAME <i>Amanda?</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Amanda Spuman</i>			ADDRESS <i>1205 N. Caroline St</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>15331</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH <i>Malignant Lymphoma Colon</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH <i>?</i>				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0 NONE</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>NONE</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 9</i> 1966 to <i>May 29</i> 1967, that (I) (we) last saw the deceased alive on <i>May 28</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Bernard Harris Sr</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>6/1/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Bernard Harris Sr</i>					23D. ADDRESS <i>1202 N Caroline St</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>6/2/67</i>			24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial</i>			24D. LOCATION (City, town, or county) (State) <i>Arbutus, Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 1 1967</i>			25B. NAME OF REGISTRAR <i>Q. E. E. E.</i>			25C. FUNERAL DIRECTOR <i>Spauld & Co.</i>			ADDRESS <i>1129 N. Caroline St</i>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5306	
BIRTH NO. 67 5306		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) David Jackson		2. DATE AND HOUR OF DEATH 5-30-1967 4:10 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 8-02			
D. STREET ADDRESS (If rural, give location) 1724 COLLINGTON AVENUE - 21213					
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/27/20	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pay load operator American Standard Inc		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE			
14. MOTHER'S MAIDEN NAME NAPPER, Emma		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 223-18-8071		17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Avenue, Balto. Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Adeno carcinoma of lung		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3-20 19 67 to 5-30 19 67, that (we) last saw the deceased alive on 5-30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE James W. Keller		M.D. Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff <input checked="" type="checkbox"/> Phys.		23B. DATE SIGNED 5-30-1967	
23C. PHYSICIAN'S NAME (Type) James W. Keller		M.D. 23D. ADDRESS 4940 Eastern Avenue, Balto. Md. 21224 Baltimore City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/3/67		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery Baltimore Md	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR P. E. E. Jackson	
25C. FUNERAL DIRECTOR 712-14 E. North Ave Elmer E. Buckner Baltimore, Md. 21202					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

John T. Smith

John T. Smith

Kingland General Hospital

Kingland
Baltimore
1204 W 40th St

F W Widenor

3/4/64 83

Hardy

Kingland

U-2 W

Hester Frantz

312-20-314 Broadway
(2nd)

same

Metastatic Carcinoma Breast

No

W. Michael Hall

June 1

March 22

63

June 1

6/1/63

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE

HEWING

2. DATE AND HOUR PRONOUNCED DEAD

5-27-67

11:40 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

H3 SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

805 Williams Street

21230

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

MARCH 19, 1886

9. AGE (In years
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John W Shock

14. MOTHER'S MAIDEN NAME

Ella E. Witcomb

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Goodman 3741 Elm Ave

18.

E903.5

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Ventricular fibrillation during surgery

RISKY

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) for repair of fractured femur

(C) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypertensive cardiovascular disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

5-26-67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

Fracture of left femur

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

900 Block of Light Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 22 :67 4:00 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell on street

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-28-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

5/31/67

23C. NAME of CEMETERY or CREMATORY

JOHNS PRES. Cemetery BALTO, Md

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 2 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Burgee Funeral Home 3631 Falls Rd

ADDRESS

VALLEY SOUTH

WALLEY FORMER

CHURCH OF THE

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

WALLEY

FUNERAL DIRECTOR: IMPORTANT

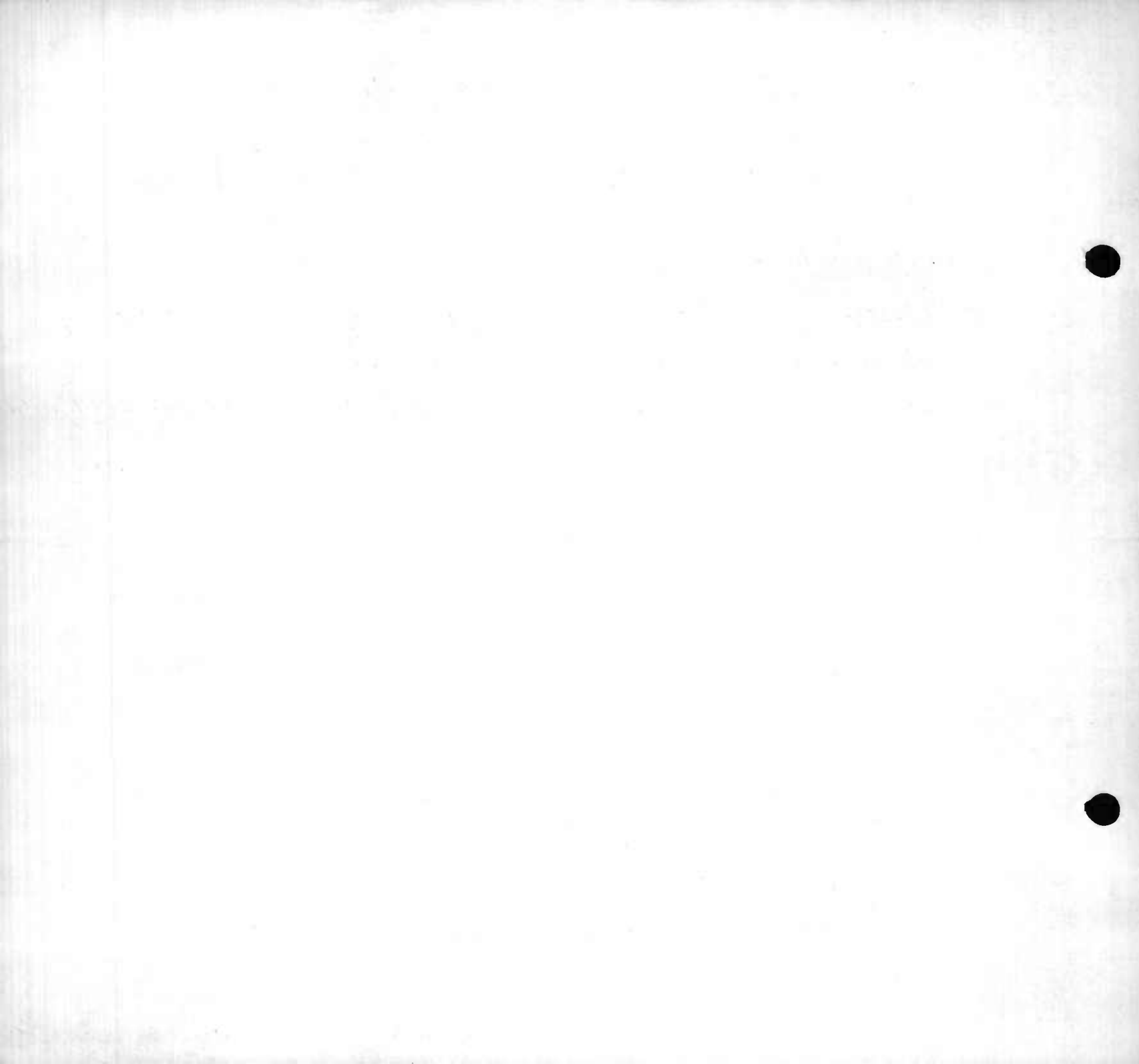
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5309				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5309	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Edna Marie Brown		May 29 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
North Charles General Hosp				Maryland			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				3425 Hickory Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Female	White	WIDOWED, DIVORCED (specify) Married	JAN 30 1903	64	Housewife	Maryland	USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas Tracey				Susan Wisner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Joseph H. Brown 3425 Hickory Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)				(A) DUE TO		25 years	
				(B) DUE TO		25 years	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Ischemic heart disease		15 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/12/63 19 to 5/29/67 19 that (I) (we) last saw the deceased alive on 5/11/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
A Lewis Kolodny M.D.						6/1/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
A Lewis Kolodny				3900 N Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		2 June 67		Poplar Grove Cem		Warren, Balto Co Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 2 1967		Robert E. ...		Burgee Funeral Home		3631 Falls Rd	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5310</u>	
BIRTH NO. <u>67 5310</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Stanley S Skirka</u>		2. DATE AND HOUR OF DEATH <u>May 27 1967</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>00643 Tunbridge Rd</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		<u>27-48</u>	
D. STREET ADDRESS (If rural, give location) <u>643 Tunbridge Rd.</u>		5. SEX <u>Male</u>		6. RACE <u>White</u>	
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u>		8. DATE OF BIRTH <u>Oct 4 1906</u>		9. AGE (In years last birthday) <u>60</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Tailoring</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>		13. FATHER'S NAME <u>Stanislaus Skirka</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215014503</u>		17. INFORMANT <u>Ronald Kirk</u>	
ADDRESS <u>643 Tunbridge Rd</u>		18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>		(A) DUE TO		<u>18 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cardiac Arrhythmia</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/22/67</u> 19 <u>67</u> to <u>5/27</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/26/</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE <u>Herman Brecher</u> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/29/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Herman Brecher</u> M.D.		23D. ADDRESS <u>443 E. 25th St</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/31/67</u>		24C. NAME of CEMETERY or CREMATORY <u>LONDON PARK Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>BALto Co. Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Burber Funeral Home</u>	
				ADDRESS <u>3631 Falls Rd</u>	



FUNERAL DIRECTOR: IMPORTANT

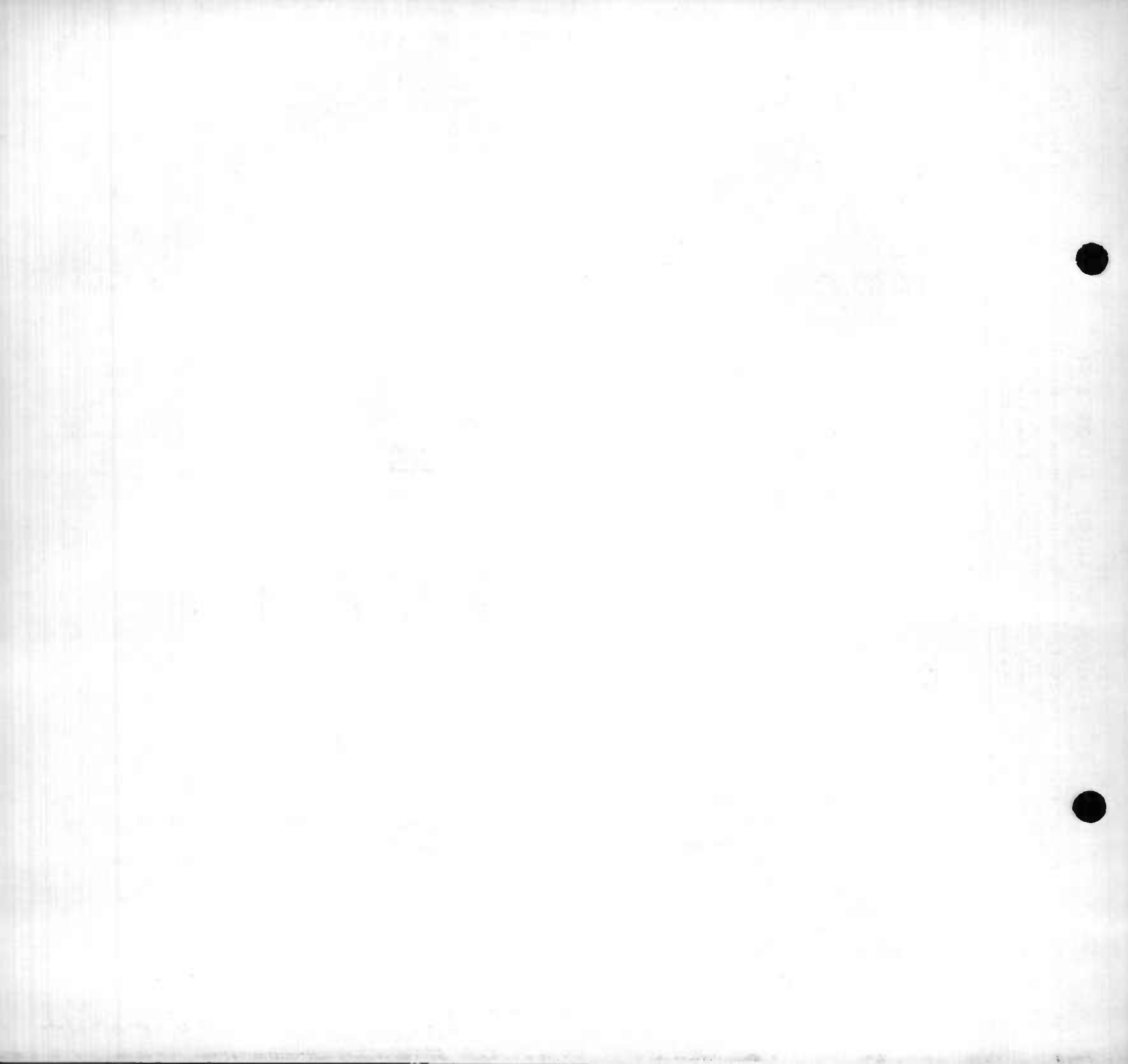
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5311		CERTIFICATE OF DEATH		Registered No. 67 5311	
1. NAME OF DECEASED (Type or Print) JOHN PRICE				2. DATE AND HOUR OF DEATH MAY 31, 1967 7 15 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. OF MD HOSP 38 BALTO. MD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21-02 D. STREET ADDRESS (If rural, give location) 612 ARCHER ST #30					
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-24-88		9. AGE (In years last birthday) 79		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Price				14. MOTHER'S MAIDEN NAME Minnie					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Jocely Price 612 Archer St				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 332X1Y260X				CAUSE OF DEATH (A) Pneumonia, Apneustic DUE TO (B) Cerebral Thrombosis DUE TO (C) Cerebral Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day Yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes Mellitus; Congestive Heart Failure					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that at (this hospital) attended the deceased from 5-29 1967 to 5-31 1967 , that at (we) last saw the deceased alive on 5-31 1967 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (we) (did) (did not) view the body after death.									
23A. SIGNATURE William R. Law M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-31-67	
23C. PHYSICIAN'S NAME (Type) WILLIAM R. LAW				23D. ADDRESS M.D. UNIV. OF MD HOSP. BALTO. MD					
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 6/3/1967		24C. NAME OF CEMETERY or CREMATORY W. H. AUBURN		24D. LOCATION (City, town, or county) (State) BALTO MD			
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR R. E. F. J. E. F.		25C. FUNERAL DIRECTOR Marshall P. Hays 635 N. Gilmor St					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5312</u>	
BIRTH NO. <u>67 5312</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ANN SINGLETON</u>		2. DATE AND HOUR OF DEATH <u>6/1/67</u> <u>18:23</u> <u>A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		A. STATE <u>MD</u> B. COUNTY <u>BALT</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALT</u>			
		D. STREET ADDRESS (If rural, give location) <u>904 N GILMORE ST</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>4/14/46</u>	9. AGE (In years last birthday) <u>21</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOSEPH SINGLETON</u>			
14. MOTHER'S MAIDEN NAME <u>LILIAN VEREEN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>212-42-2340</u>		17. INFORMANT ADDRESS <u>S.W. TIESENGA M.D. UNIVERSITY HOSP. BALT MD.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Metastatic ovarian neoplasia</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>1/25/67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ovarian neoplasm</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> 19 <u>67</u> to <u>6/1</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/1</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S.W. Tiesenga</u>				23B. DATE SIGNED <u>6/1/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>S.W. TIESENGA</u>				23D. ADDRESS M.D. <u>University Hosp Balt Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>6-1-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Whiteville N.C.</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 2 1967</u>			
25B. NAME OF REGISTRAR <u>Charles E. Tiesenga</u>		25C. FUNERAL DIRECTOR ADDRESS <u>212 N Gilmore St</u>			



1
P-420

67 5313

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5313

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES F. POLEK

2. DATE AND HOUR PRONOUNCED DEAD

5-31-67

9:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 402 S. CONKLING STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

402 S. Conkling Street 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

11/13/1911

9. AGE (In years last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Proprietor-Ret.

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Polek

14. MOTHER'S MAIDEN NAME

Ludwika Kutz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-01-0061

17. INFORMANT

ADDRESS

Mr. Joseph M. Polek, 3209 Ramona Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Pulmonary fibrosis and cor pulmonale

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Inactive pulmonary tuberculosis

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-31-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6/3/67

23C. NAME of CEMETERY or CREMATORY

Holy Rosary

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 2 1967

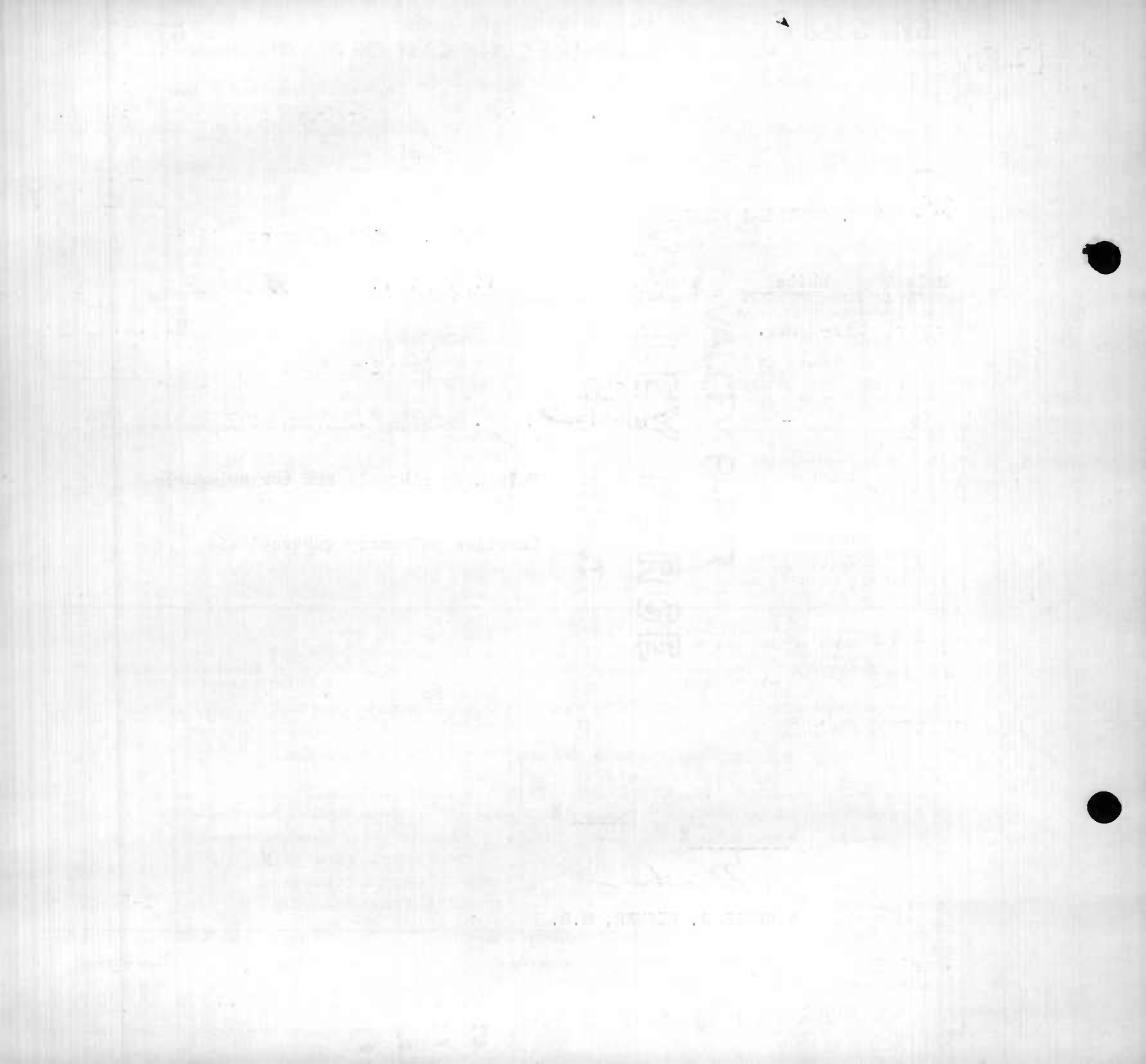
24B. NAME OF REGISTRAR

Robert S. Fisher

24C. FUNERAL DIRECTOR

M.F. SADOWSKI & SONS, 1808 EASTERN AVE

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

THERESA (Sieber)

KAUFMAN

2. DATE AND HOUR PRONOUNCED DEAD

May 29, 1967

2:37 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6508 Belle Vista Road

#6

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Sept. 10, 1931

9. AGE (In years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bookkeeper

10B. KIND OF BUSINESS OR INDUSTRY

Harvey House Rest.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Sieber

14. MOTHER'S MAIDEN NAME

Naomi Wirth

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

217-26-2244

17. INFORMANT

ADDRESS

John Kaufman, husband, above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Rheumatic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S Werner U. Spitz, M.D.
NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/30/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/2/67

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

(State)

Balto., Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 2 1967

24B. NAME OF REGISTRAR

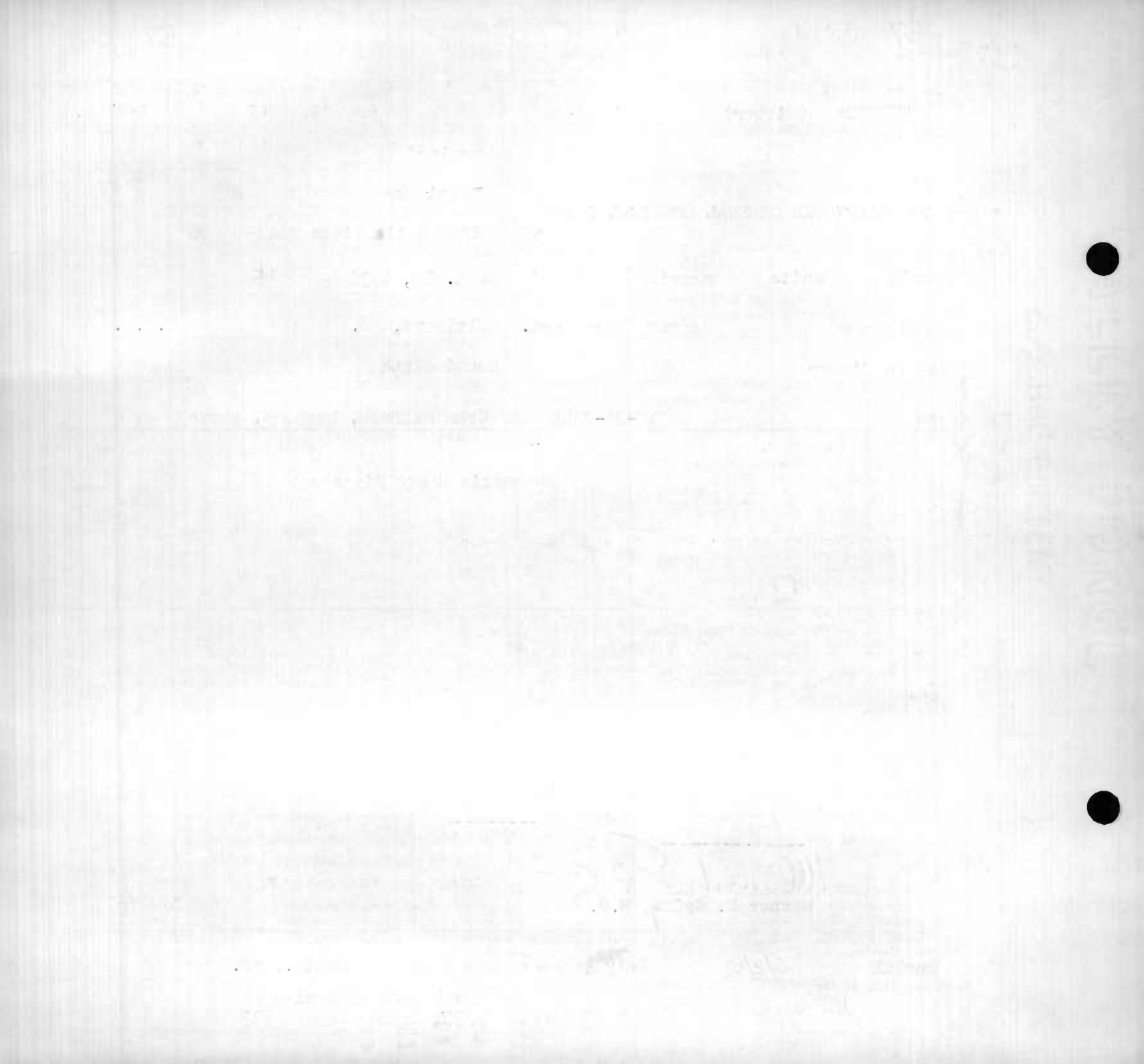
Albert E. Spitz, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home

ADDRESS

3331 Brehms Lane #13



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 67 5315					CERTIFICATE OF DEATH					Registered No. 67 5315									
1. NAME OF DECEASED (Type or Print) SAMUEL GOLDMAN					2. DATE AND HOUR OF DEATH May 31, 1967 9:45 A.M.														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location) JEWISH CONV HOME 4601 PALL MALL ROAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-16 D. STREET ADDRESS (If rural, give location) 4601 PALL MALL RD														
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH Nov, 1877		9. AGE (In years last birthday) 89		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret					10B. KIND OF BUSINESS OR INDUSTRY TAILOR					11. BIRTHPLACE (State or foreign country) Russia					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME JACOB					14. MOTHER'S MAIDEN NAME TOBA					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 212-63-9251				
					17. INFORMANT MRS BEATRICE ENGELMAN					ADDRESS 6282 TOWNBROOK DRIVE									
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Central Vascular thrombosis										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 7-27-1950 to 5-31-1967 , that (I) (we) last saw the deceased alive on 5-29-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Irvin Sauter M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED 5-31-67									
23C. PHYSICIAN'S NAME (Type) IRVIN SAUTER M.D.										23D. ADDRESS 6905 Park Hgts Ave									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 5/2/1967					24C. NAME of CEMETERY or CREMATORY ROSEDALE					24D. LOCATION (City, town, or county) (State) BALTO. MD				
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967					25B. NAME OF REGISTRAR Robert S. Taylor, M.D.					25C. FUNERAL DIRECTOR Sylvan S. Quisenberry, Inc					ADDRESS Garrison, Md				

Handwritten text at the top of the page, possibly a title or header.

Handwritten text in the middle section of the page.

Handwritten text in the lower middle section of the page.

Handwritten text at the bottom of the page, including a signature and date.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Register No. 67 5316	
BIRTH NO. 67 5316		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Gregson, Mrs. Josephine Swall		2. DATE AND HOUR OF DEATH May 31, 1967 10:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.			
FULL NAME OF HOSPITAL OR INSTITUTION North Charles Gen Hosp.		(If not in hospital or institution, give street address or location) 2724 N. CHAS. ST. #18		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 6510 Old Orchard Rd.	
5. SEX Female	6. RACE White	7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 5/14/01	9. AGE (In years lost birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Swall				14. MOTHER'S MAIDEN NAME Anna Durgine			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 242-03-3710		17. INFORMANT Robert W. Gregson (Husband)		ADDRESS	
18. 581.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatic failure				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Coronary, poss. fatty, 2 yrs			
				(C) to			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lupus erythematosus, systemic 10 yrs							
19A. DATE OF OPERATION Jan. 31/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Portal Hypertension		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the physician) attended the deceased from 11/3/66 to 5/24/67 and that (I) (the physician) last saw the deceased alive on 5/21/67 and that in (my) (the physician's) opinion death occurred on the date and hour and from the causes stated above. (I) (the physician) (did) (not) view the body after death.							
23A. SIGNATURE Leonard H. Flaxman				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/31/67	
23C. PHYSICIAN'S NAME (Type) Leonard H. Flaxman		23D. ADDRESS 2702 N. Charles St. City 21202					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-2-67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR Robert W. Gregson		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Baltimore, Md. 21212	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5317				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5317	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MATSKUH, ELIZABETH				2. DATE AND HOUR OF DEATH 05 31 67		2:50A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21230 25-42			
				D. STREET ADDRESS (If rural, give location) 3004 MALLVIEW ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 8-30-90	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK ZUMKUFSKI				14. MOTHER'S MAIDEN NAME ANNIE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary Worch - 3004 Mallview Road		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO arteriosclerotic Cardiovascular Disease (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH years 20 days 8 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? 3004 Mallview Rd.		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 5-11-67		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall at home getting out of bed			
22. I certify that (I) (this hospital) attended the deceased from MAY 11 1967 to MAY 31 1967, that (I) (we) last saw the deceased alive on MAY 31 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Paul F. Kaminski				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED May 31, 1967	
23C. PHYSICIAN'S NAME (Type) PAUL F. KAMINSKI				23D. ADDRESS ST. AGNES HOSPITAL-CATON & WILKENS AV			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/3/67		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR John E. Denny		25C. FUNERAL DIRECTOR JOHN F. DENNY, INC.		ADDRESS 715 Light St.	

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

BIRTH NO. **67 5318** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 5318**

M.E. CASE NO.

NAME OF DECEASED
(Type or Print)**JOSEPH R. MORASCO**

2. DATE AND HOUR PRONOUNCED DEAD

May 29, 1967 6:53 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**3414 ERDMAN AVENUE**4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3414 Erdman Avenue**26-03**

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)**Widowed**

8. DATE OF BIRTH

March 17-19039. AGE (In years
last birthday)**63**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Brick Layer**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy12. CITIZEN OF
WHAT COUNTRY?**U S A**

13. FATHER'S NAME

Michael Morasco

14. MOTHER'S MAIDEN NAME

Unknown15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.**0054-03-3280**

17. INFORMANT

ADDRESS

Gertrude DeRespinis 822 21st Dr Astoria L.I

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Lobar Pneumonia**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)**Werner U. Spitz, M.D.**

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/30/6723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

6-1-67

23C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 2 1967

24B. NAME OF REGISTRAR

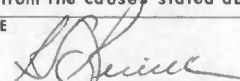
Robert E. Farber

24C. FUNERAL DIRECTOR

Walter Dabrowski 1005 Dundalk Avenue

ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5319		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5319	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) HEANEY, JR., CLEMENT T.			2. DATE AND HOUR OF DEATH 5-31-67 4:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1210 HAVERHILL ROAD 21229		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-28-19	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY DEPT. OF AGRICULTURE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CLEMENT T., SR.			14. MOTHER'S MAIDEN NAME MARY A MORRIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES W W II		16. SOCIAL SECURITY NO. 213 12 0357		17. INFORMANT ADDRESS CATON AVE. 21229	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANAPLASTIC CARCINOMA OF THE LUNG WITH MULTIPLE METASTASIS INTERVAL BETWEEN ONSET AND DEATH 6-8 MONTHS.					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month 1 Day (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 4-15-1967 to 5-31-1967 , that (X) (we) last saw the deceased alive on 5-31-1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) R REVILLA				23B. DATE SIGNED 05/31/67	
23D. ADDRESS ST AGNES HOSPITAL, BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-3-1967	24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229	

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

10-12-57

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO. 67 5320

67 5320

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MILTON W. WHALEN

2. DATE AND HOUR PRONOUNCED DEAD

May 29, 1967

3:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1135 Newfield Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

JUNE 30, 1894

9. AGE (In years
last birthday)

72

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Auto Sales

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Stephen Whalen

14. MOTHER'S MAIDEN NAME

EMMA E. GEMUNDT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

705-10-2260

17. INFORMANT

ADDRESS

STEPHEN W. WHALEN

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, locality, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/30/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/2/67

23C. NAME of CEMETERY or CREMATORY

Loudon PK.

23D. LOCATION (City, town, or county)

BALTO.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 2 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

E. S. Mac Nabbs

ADDRESS

301 Frederick Rd
Baltimore

Widowed

June 30, 1874

Age 24

Stephen W. Whaley

Married

Emma E. Conant

Stephen W. Whaley

8/17

6/17/74

8/17/74

3rd of 1874

1874

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

ROBERT K. NORRIS

2. DATE AND HOUR PRONOUNCED DEAD

5-26-67

8:55 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34 BON SECOUR HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Howard Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Ellicott City

D. STREET ADDRESS (If rural, give location)

22 Avoca Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7/8/15

9. AGE (in years
last birthday)

50 51

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sheet Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY

Finglas Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Jack Norris

14. MOTHER'S MAIDEN NAME

Charlotte - - -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Charlotte H. Kvech 928 Sidgley Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Stab wound of chest - (back)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Rear of 2100 Blk W. Lexington Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 26 '67 7:50 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed and robbed

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

5-27-67

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

5/31/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 2 1967

H. H. Hubbard

Howard H. Hubbard

4107 Wilkens Ave. 21229

CONFIDENTIAL

1
H-626

67 5322

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 5322

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)
EARLE

R.

HARSHER

2. DATE AND HOUR PRONOUNCED DEAD

May 29, 1967

2:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MarylandB. COUNTY
Anne Arundel Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Linthicum Heights

D. STREET ADDRESS (If rural, give location)

301 Johns Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9/21/92

9. AGE (in years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer - retired

10B. KIND OF BUSINESS OR INDUSTRY

B & O R.R.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

William Harsher

14. MOTHER'S MAIDEN NAME

Mandela - - -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

X No No

16. SOCIAL
SECURITY NO.

705-12-0269A

17. INFORMANT

Mrs. Marjorie Harsher 301 John Ave. 21090

ADDRESS

Linthicum Hgts. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary Embolism complicating

XXXXX

Multiple injuries.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Rolling Rd., S. Hilton Ave., Balto. Co.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
May 4 '67 P

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Driver of auto which ran off roadway.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/29/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/1/67

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

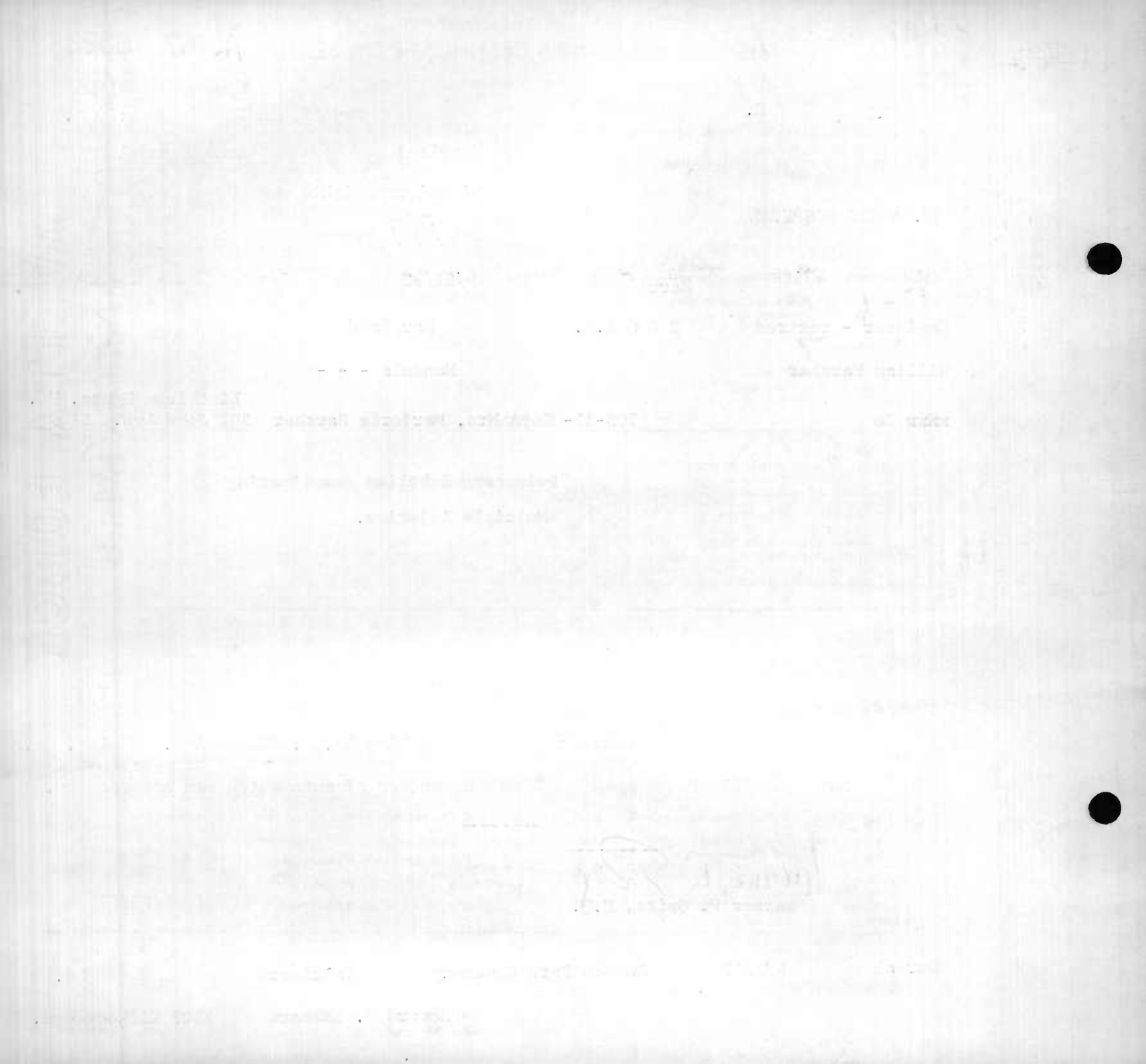
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Howard H. Hubbard

4107 Wilkens Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 67 5323					REGISTERED NO. 67 5323						
CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print) FOARD, CATHERINE PAULINE P.					2. DATE AND HOUR OF DEATH 5-28-67 2:15A M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21234 53-00 D. STREET ADDRESS (If rural, give location) 1732 REDWOOD AVENUE						
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 06 14 94	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME GEORGE BROWN					14. MOTHER'S MAIDEN NAME ELIZABETH CANOBALL Connabaugh						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST. AGNES RECORDS -CATON & WILKENS AVE						
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					19. DATE OF OPERATION 5/3/67			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from MAY 19 1967 to MAY 28 19 67 , that (I) (we) last saw the deceased alive on MAY 28, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE 					M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 05 28 67			
23C. PHYSICIAN'S NAME (Type) FEDERICO POLLICINA					23D. ADDRESS M.O. ST. AGNES HOSPITAL-CATON & WILKENS AVE						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/31/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery			24D. LOCATION (City, town, or county) Baltimore, Maryland 21229				
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967			25B. NAME OF REGISTRAR Robert E. Hubbard			25C. FUNERAL DIRECTOR Howard H. Hubbard			ADDRESS 4107 Wilkens Ave. 21229		

12-1-67

2-28-67

ST. LOUIS, MISSOURI

ST. LOUIS

ST. LOUIS

ST. LOUIS

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

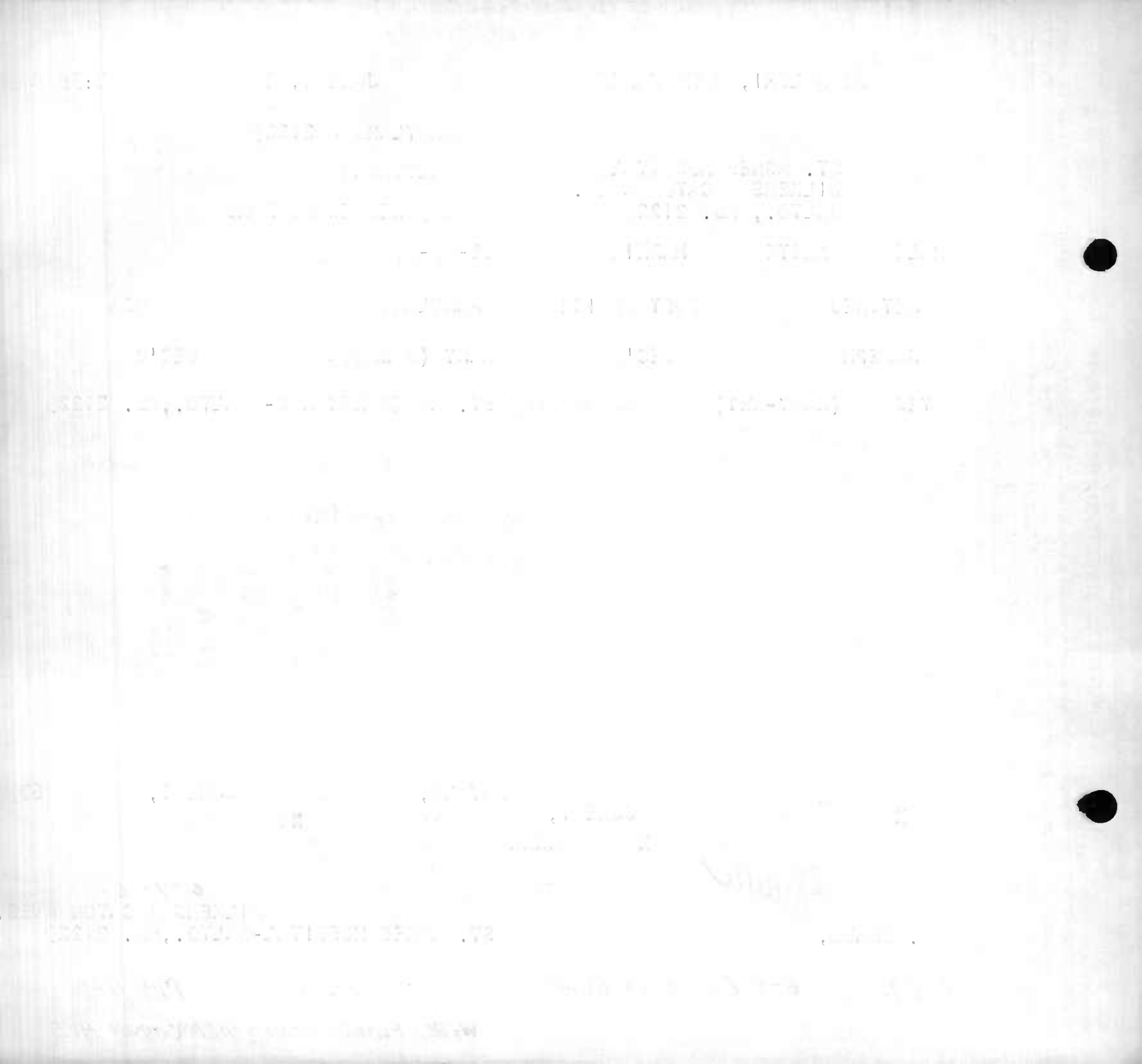
ST. LOUIS, MISSOURI

ST. LOUIS, MISSOURI

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

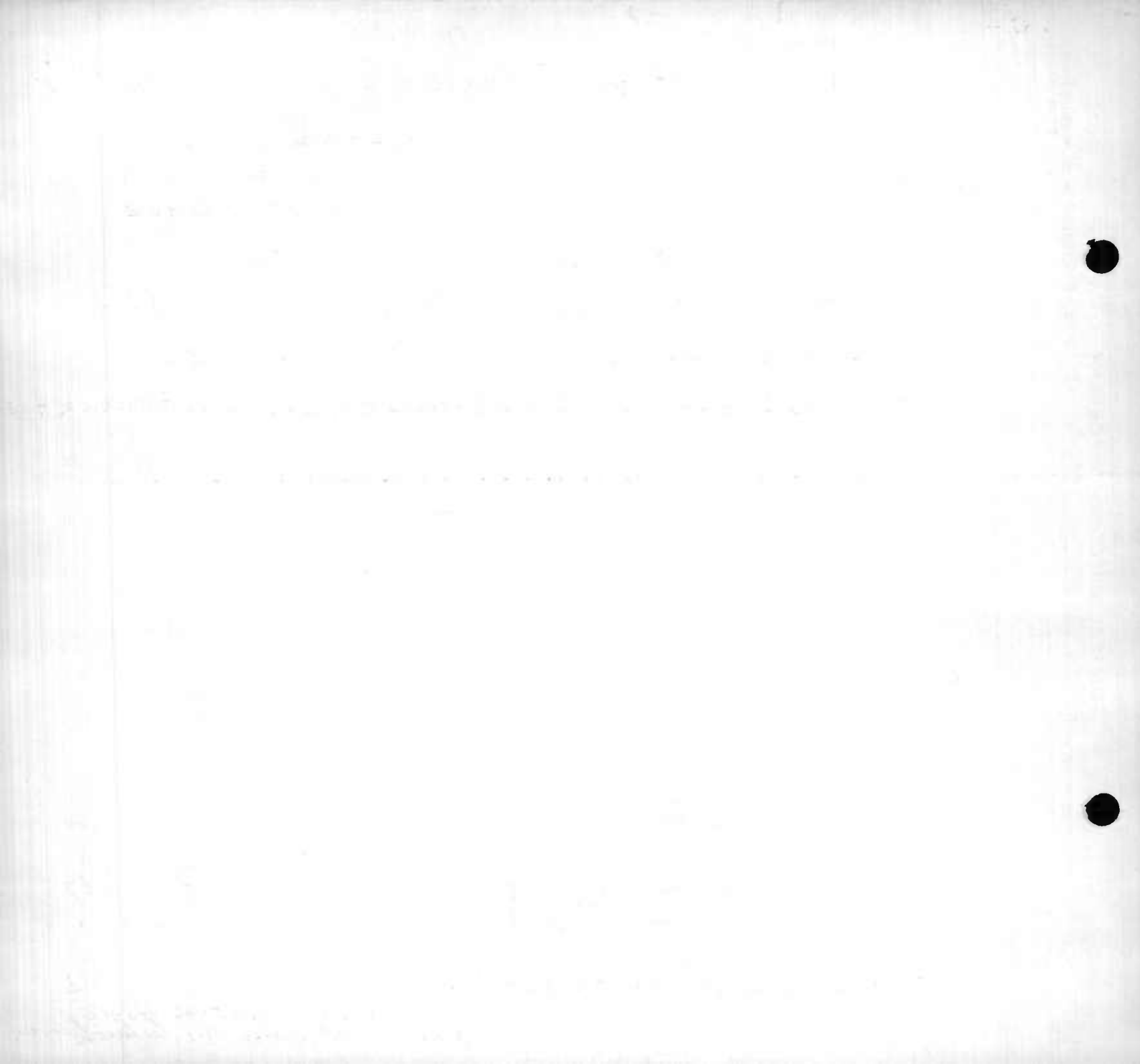
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5324		Registered No. 67 5324	
CERTIFICATE OF DEATH				DATE AND HOUR OF DEATH		JUNE 1, 1967 4:35 A.M.	
1. NAME OF DECEASED (Type or Print) JESKULSKI, JOHN JAMES				2. DATE AND HOUR OF DEATH JUNE 1, 1967 4:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO., MD. 21229		(If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 21229	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 805 WEDGEWOOD ROAD					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 12-05-97	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY POST OFFICE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH DEC'D				14. MOTHER'S MAIDEN NAME MARY (SPORNY) DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES (NAVY-WW1)		16. SOCIAL SECURITY NO. 216-44-2887		17. INFORMANT ADDRESS ST. AGNES RECORDS- BALTO., MD. 21229			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 1 week							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerotic cardiovascular disease Hypertension							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from MAY 24, 1967 to JUNE 1, 1967 , that (X) (we) last saw the deceased alive on JUNE 1, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.							
23A. SIGNATURE B. BRAUN				23B. DATE SIGNED 6-1-67			
23C. PHYSICIAN'S NAME (Type) B. BRAUN		23D. ADDRESS ST. AGNES HOSPITAL-BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-5-67		24C. NAME of CEMETERY or CREMATORY HOLY ROSARY CEMETERY BALTO.		24D. LOCATION (City, town, or county) (State) MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR R. E. Johnson		25C. FUNERAL DIRECTOR ADDRESS WELER FUNERAL HOMES 5311 EDMONDSON AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5325		CERTIFICATE OF DEATH		Registered No. 67 5325	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Louis C. GABRIO		2. DATE AND HOUR OF DEATH 5-29-67 10 45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 48 MARKET PLACE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH July 20, 1913	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10B. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Louis Gabrio		14. MOTHER'S MAIDEN NAME Bosies			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1946 to 1949		16. SOCIAL SECURITY NO. 215-05-7520		17. INFORMANT ADDRESS Barbara M. Schwab 2101 Frederick Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebro vascular accident		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 30 hours?	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-29-1967 to 5-29-1967 , that (I) (we) last saw the deceased alive on 5-29-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Venkatachalam		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-2-67	
23C. PHYSICIAN'S NAME (Type) B. VENKATACHALAM		23D. ADDRESS MERCY HOSPITAL BALT. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-2-67		24C. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.					
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR A. J. Miller		25C. FUNERAL DIRECTOR ADDRESS 650 E. Johnson Rd. Baltimore	



67 5326

BALTIMORE CITY HEALTH DEPARTMENT

67 5326

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HAZEL BAILEY

2. DATE AND HOUR PRONOUNCED DEAD

June 1, 1967 7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1219 Luzerne Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

June 30 - 1923

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore

12. CITIZEN OF
WHAT COUNTRY

USA

13. FATHER'S NAME

William Bailey

14. MOTHER'S MAIDEN NAME

Emma Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mary Bailey

ADDRESS

Sawee

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 1, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-6-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cent

23D. LOCATION (City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 2 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Clayton Nelson 1000 Brentwood

ADDRESS

TABLE OF CONTENTS

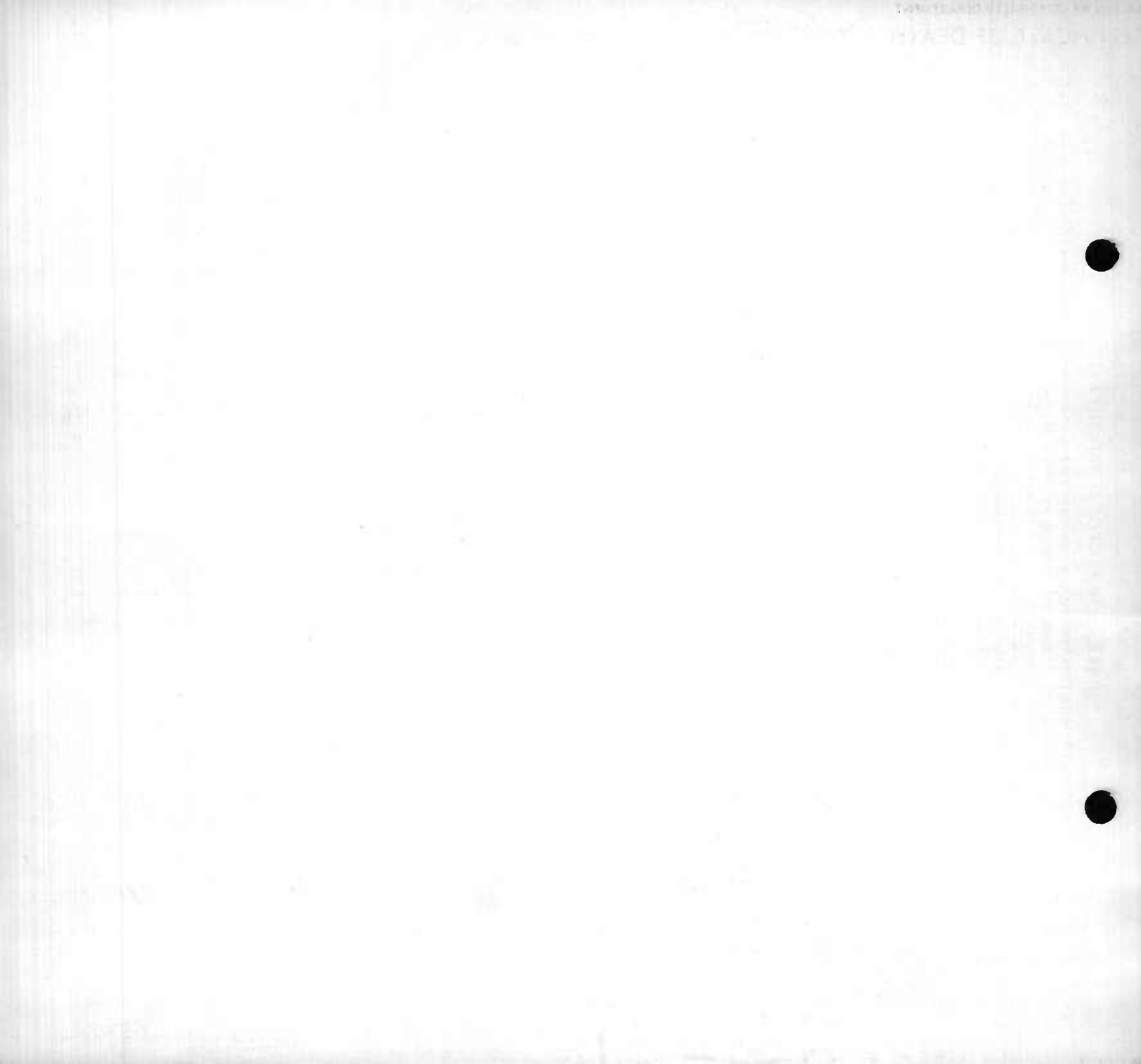
CHAPTER I

CHAPTER II

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5327					Registered No. 67 5327				
M.E. CASE NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) WALKER, ROBERT					2. DATE AND HOUR OF DEATH 5/31/67 2:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 16-07				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of M.D.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 3019 Baker St.				
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH 10-6-21	9. AGE (In years last birthday) 45	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane opr.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Walker				14. MOTHER'S MAIDEN NAME Mamie Eggs					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) YES				16. SOCIAL SECURITY NO. 224-18-1550		17. INFORMANT Lee Amine Jones 2902 Keyworth Ave.		ADDRESS	
18. 331 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronal vascular accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hyper-tension				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5/30/1967 to 5/31/1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 5/30/1967 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.									
23A. SIGNATURE I. Rajae						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/31/67	
23C. PHYSICIAN'S NAME (Type) IRAJ REJAIE						23D. ADDRESS Lutheran Hospital of Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6-5-67		24C. NAME OF CEMETERY or CREMATORY Balto Nat Cent		24D. LOCATION (City, town or county) (State) Balto Md Md		
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967			25B. NAME OF REGISTRAR R. L. B. E. Taylor, M.D.			25C. FUNERAL DIRECTOR Elizabeth Wilson 1000 Brantley			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5328	
BIRTH NO. 67 5328		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MR ANGUS R. GROSS		2. DATE AND HOUR OF DEATH MAY 30, 1967 9 30 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL 34 2025 WEST FAYETTE STREET BALTIMORE 23, MARYLAND 21223		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 29			
		D. STREET ADDRESS (If rural, give location) 806 Glen Allen Dr			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-9-83	9. AGE (In years lost birthday) 84	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CANADA NEW-YORK	
13. FATHER'S NAME ALBERT GROSS		14. MOTHER'S MAIDEN NAME ELIZABETH		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-32-9704		17. INFORMANT Mrs. Mary Gross 806 Glen Allen Dr. - 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular disease		CAUSE OF DEATH (A) DUE TO uremia (B) DUE TO Anemia (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 19 19 67 to MAY 30 19 67 , that (I) (we) last saw the deceased alive on MAY 30 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jung Kook Lee M.D.				23B. DATE SIGNED 5-30-67	
23C. PHYSICIAN'S NAME (Type) Jung Kook Lee M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 6/2/67		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Mausoleum	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave	
				ADDRESS	

1944-1945
1946-1947
1948-1949
1950-1951
1952-1953
1954-1955
1956-1957
1958-1959
1960-1961
1962-1963
1964-1965
1966-1967
1968-1969
1970-1971
1972-1973
1974-1975
1976-1977
1978-1979
1980-1981
1982-1983
1984-1985
1986-1987
1988-1989
1990-1991
1992-1993
1994-1995
1996-1997
1998-1999
2000-2001
2002-2003
2004-2005
2006-2007
2008-2009
2010-2011
2012-2013
2014-2015
2016-2017
2018-2019
2020-2021
2022-2023
2024-2025

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 67 5329

BIRTH NO. 67 5329

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Vasilio Achilea

2. DATE AND HOUR OF DEATH

7:15 AM 6/1/67

7:15 A.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE 21224, MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS

(If rural, give location)

4700 EASTERN AVENUE

21224

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9-6-03

9. AGE (in years)

63

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Restaurant

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Greece

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew

14. MOTHER'S MAIDEN NAME

Mary Simmons

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

282-07-3407

17. INFORMANT

ADDRESS

MD.

RECORDS: BCH 4940 EASTERN AVENUE BALTO. 21224,

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

Myocardial Infarction

(B) DUE TO

(C)

Baka

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/1/19 67 to 6/1/19 67,
that (I) (we) last saw the deceased alive on 5/29 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Wm A. Emerson

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/1/67

23C. PHYSICIAN'S
NAME (Type)

DR. WILLIAM A. EMERSON

M.D.

23D. ADDRESS

BALTIMORE 21224, MD.

BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6-3-67

24C. NAME OF CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 2 1967

25B. NAME OF REGISTRAR

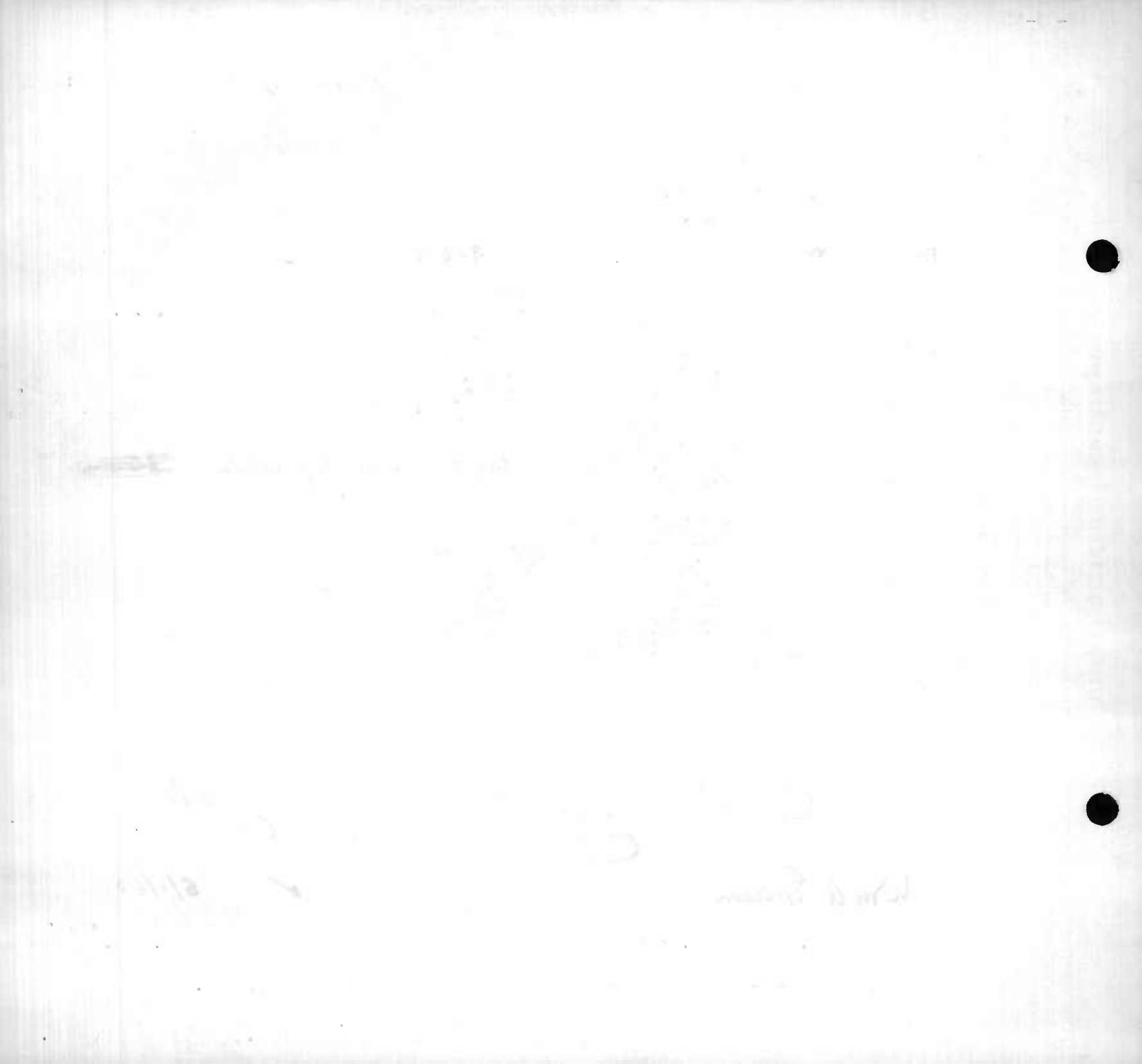
Robert E. Taylor

25C. FUNERAL DIRECTOR

Nicholas T. Matthews

ADDRESS

3021 Eastern Ave., Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5330	
BIRTH NO. 67 5330				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Mrs. Helen Paciocco				2. DATE AND HOUR OF DEATH 6/2/67 6:15 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		(If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-08			
				D. STREET ADDRESS (If rural, give location) 3916 Claremont St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3/14/06	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk.				14. MOTHER'S MAIDEN NAME unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-12-443		17. INFORMANT Mr. Daniel Paciocco		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atrial fibrillation, chronic congestive heart failure, cerebrovascular insufficiency				CAUSE OF DEATH (A) DUE TO Possible acute myocardial infarction (B) DUE TO (C) ASCVD		INTERVAL BETWEEN ONSET AND DEATH many years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 28 19 67 to June 2 19 67, that (I) (we) last saw the deceased alive on June 2 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Louis E. Drueger						23B. DATE SIGNED 6/2/67	
23C. PHYSICIAN'S NAME (Type) M.D.						23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) 6/6/67 Burial		24B. DATE Sacred Heart		24C. NAME OF CEMETERY or CREMATORY Balto. Md.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR Joseph M. Drueger		25C. FUNERAL DIRECTOR 263 S. Conkling		ADDRESS	

10/1/50

10/1/50

10/1/50

10/1/50

10/1/50

10/1/50

10/1/50

10/1/50

10/1/50

10/1/50

10/1/50

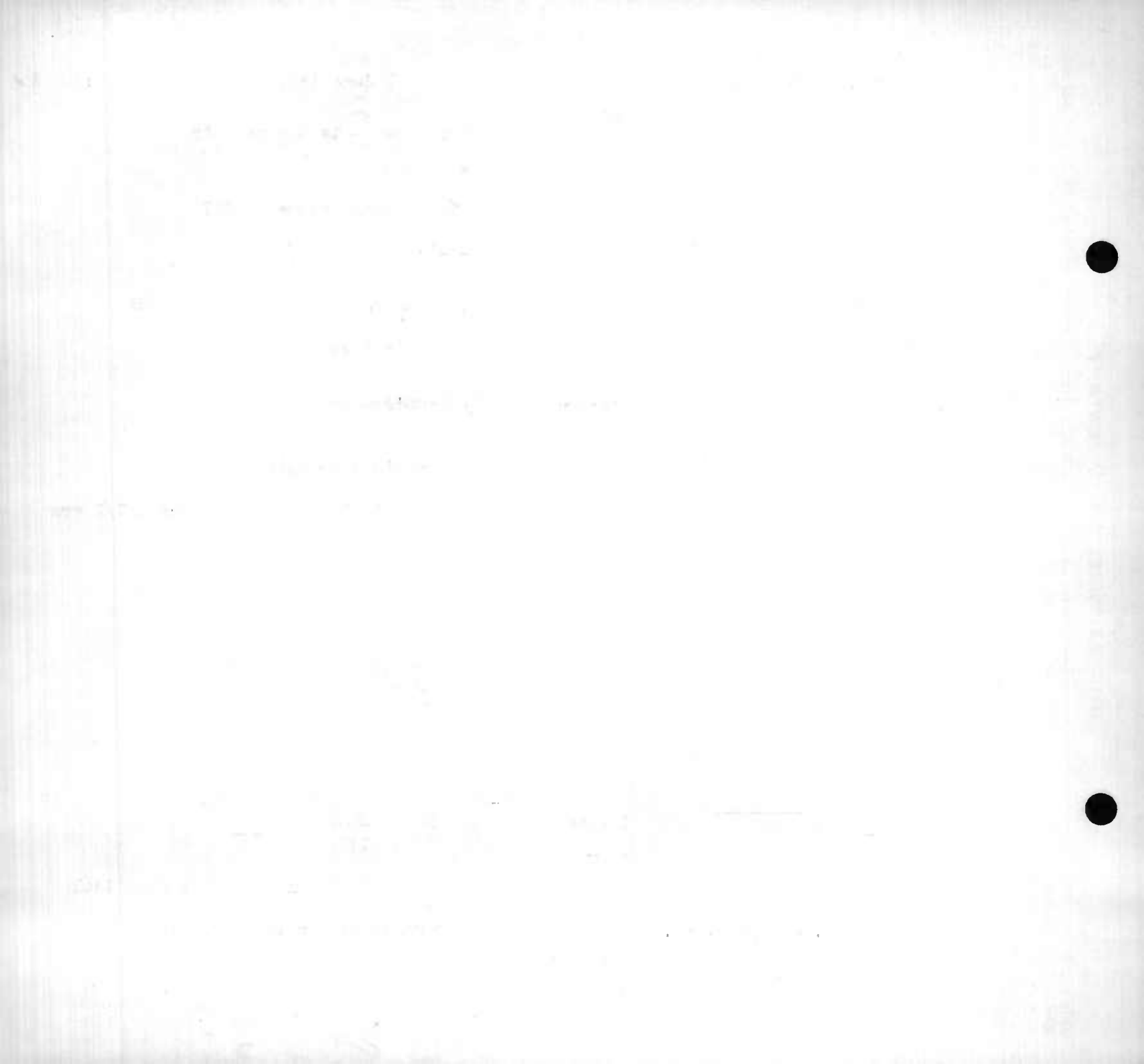
10/1/50

10/1/50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT					Certificate of Death		Registered No. 67 5331	
BIRTH NO. 67 5331		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Stewart, Muriel Rich		2. DATE AND HOUR OF DEATH 1 June 1967 7:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND University of Maryland Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2502 Linden Avenue 21217				
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED Married		8. DATE OF BIRTH 5-6-12	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Elvin Diggs				14. MOTHER'S MAIDEN NAME Maggie Rich				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Lavern Stewart 2502 Linden Ave				
18. 58101 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) R/O Postnecrotic cirrhosis DUE TO (B) R/O Lupoid hepatitis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ca 1 1/2 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.								
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5-28 19 67 to 6-1 19 67 , that (I) (we) lost saw the deceased alive on 1 June 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE S. Stogleker, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 1 June 1967		
23C. PHYSICIAN'S NAME (Type) Stanley L. Stapleton, Jr.				23D. ADDRESS University of Maryland Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Arbutus Balto Co. Md		
25A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		25B. NAME OF REGISTRAR Robert E. Fasham		25C. FUNERAL DIRECTOR Herbert E. Nutter		25D. ADDRESS 3035 W. North Ave		



1
T-656

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5332

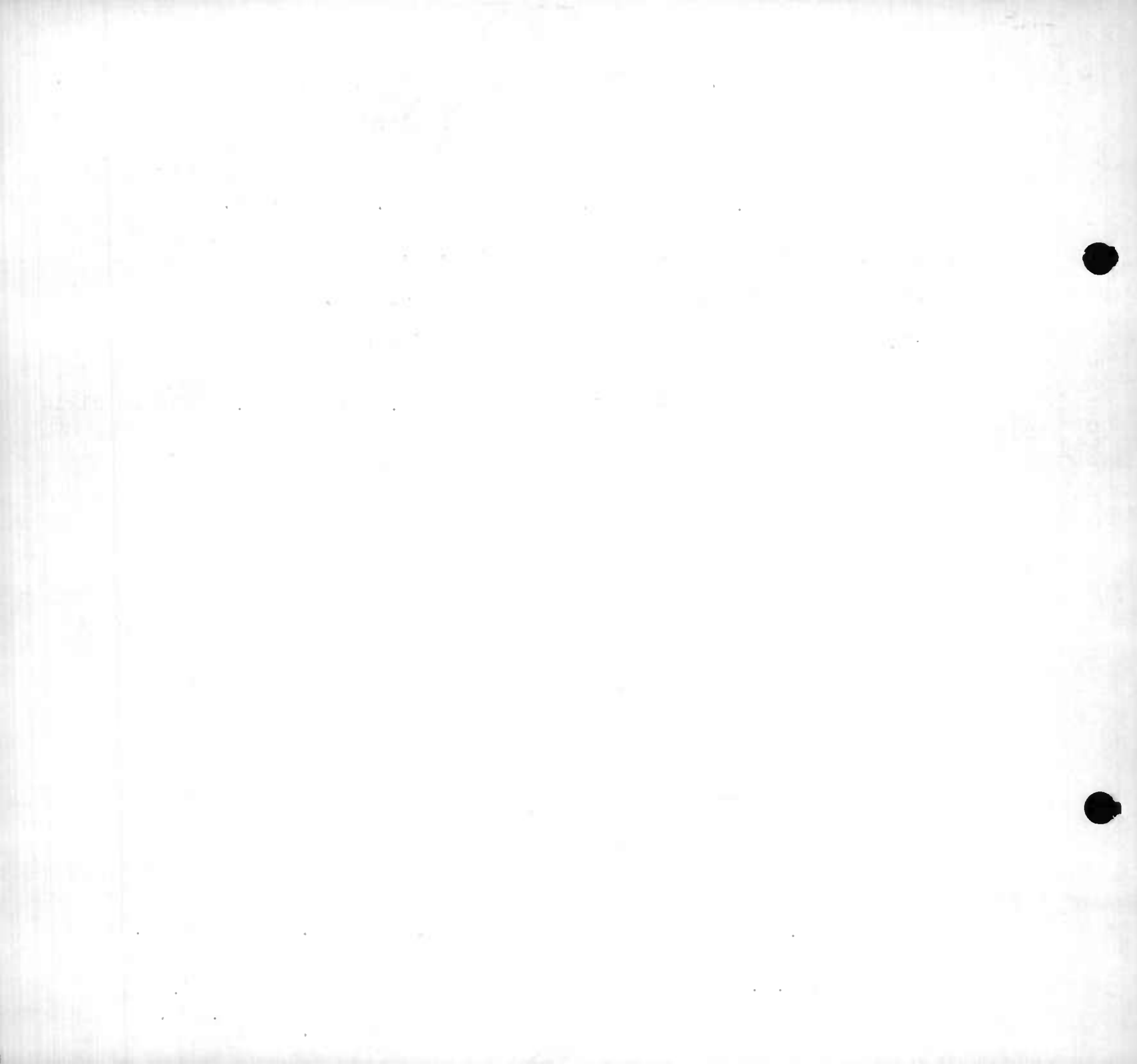
M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ISABELL TURNER				2. DATE AND HOUR PRONOUNCED DEAD June 1, 1967 8:00 A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3009 Presbury Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3009 Presbury Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec 22, 1882	9. AGE (In years last birthday) 82	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (State or foreign country) Princess Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-1159		17. INFORMANT ADDRESS Mrs. Bernice Hasty 3009 Presbury St			
18. CAUSE OF DEATH 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease DUE TO (A) _____ (B) DUE TO _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 1, 1967 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/6/67	23C. NAME of CEMETERY or CREMATORY Carver Memorial Park		23D. LOCATION (City, town, or county) (State) Laurel Anne Arundel Co, Md		
24A. DATE REC'D BY HEALTH DEPT. JUN 2 1967		24B. NAME OF REGISTRAR Robert E. Faldy		24C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter 305 W. North Ave			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5333		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5333	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) IRENE W. KORBIEN			2. DATE AND HOUR OF DEATH May 30, 1967 9 ¹⁰ P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Maryland		
00 4413 N. Charles St.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218 2711		
			D. STREET ADDRESS (If rural, give location) 4413 N. Charles St.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Sept. 24, 1896	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Business & Investor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME Julius Anton Korbien			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME Anna Seifert			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 219-32-8891			17. INFORMANT ADDRESS Katharine Korbien (Sister) 4413 N. Charles St. Baltimore 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331X I CAUSE OF DEATH (A) Cerebro-vascular Accident - Acute DUE TO (B) Cerebral & General Arteriosclerosis DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2-3 min + 3 yrs + Severe CVA 3 yrs ago.					
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension 3 yrs. +					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 3, 1966 to May 30, 1967, that (I) (we) last saw the deceased alive on May 2, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Robert W. Garis			23B. DATE SIGNED 6/1/67		
23C. PHYSICIAN'S NAME (Type) ROBERT W. GARIS			23D. ADDRESS 12 E. Eager St. Baltimore Md. 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 2, 1967		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION (City, town, or county) (State) Pikesville, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR H. E. Sander	
25C. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore Md. 21213		ADDRESS			



1

67 5334

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

67 5334

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Walter Brown

2. DATE OF DEATH

May 23, 1967

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Kenesaw Nursing Home
902601 Roslyn Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS

(If rural, give location)

2601 Roslyn Ave

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

91

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

2601 Roslyn Ave

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

ADDRESS

KENESAW NURSING HOME

18. 420.0

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Arteriosclerotic
heart disease.

(B) DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

2 months

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 5/23 1967 to 5/23 1967, that (I) (we) last saw the deceased alive on 5/19 1967 and that in (my) (our) opinion death occurred at 8:40 a.m. from the causes and on the date stated above.

23A. SIGNATURE

Attending Phys. ☒ Med. Director ☐ Staff Phys. ☐

M. D.

23B. ADDRESS

606 Edmondson Ave

23C. DATE SIGNED

5/23/67

24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

5-25-67

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 5 1967

25B. NAME OF REGISTRAR

Robert E. Stanley, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

VS 150

19670005343

THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.



FUNERAL DIRECTOR: IMPORTANT

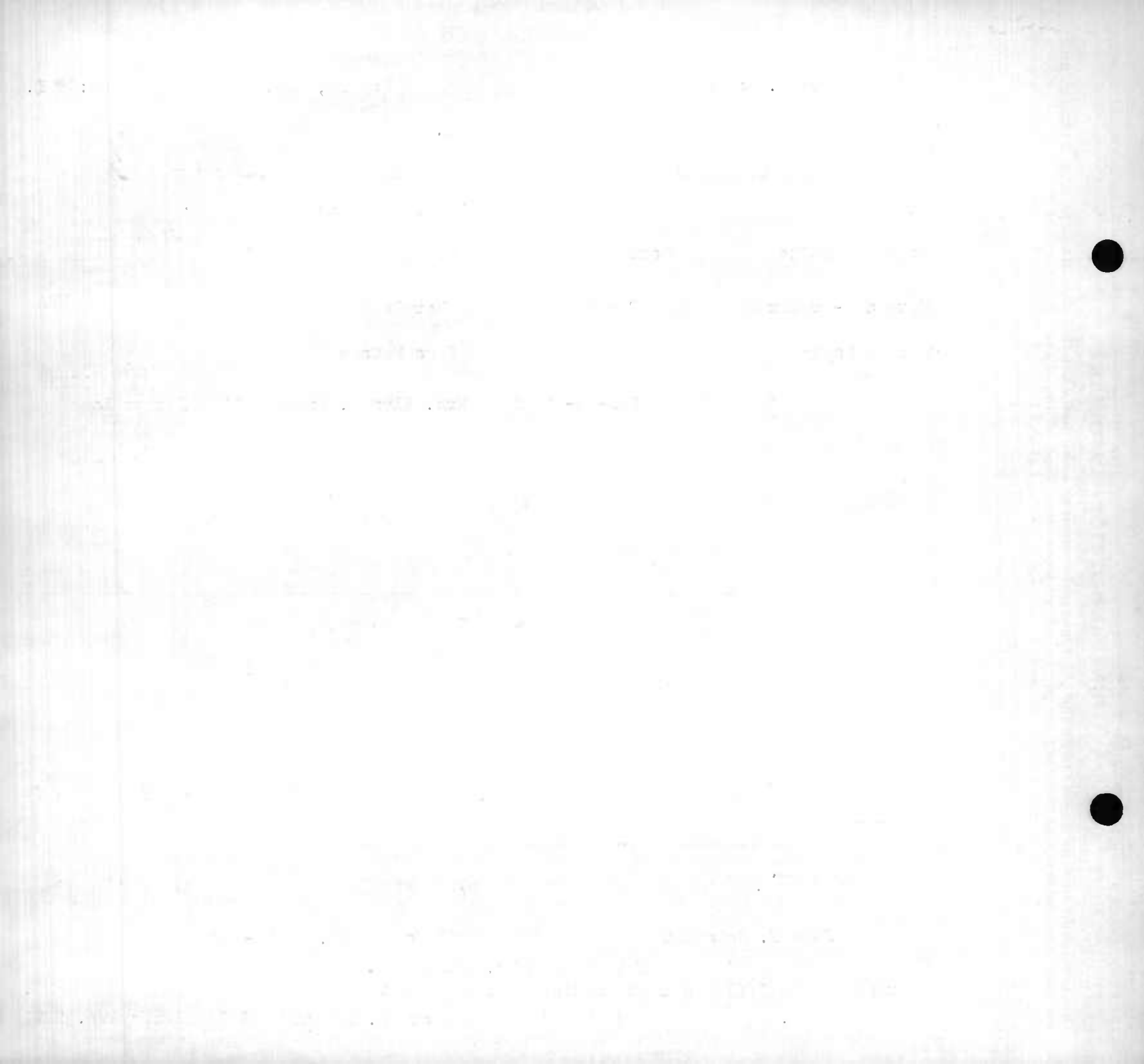
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5335	
BIRTH NO. 67 5335		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Louise J. Ebardt		May 29, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
Hood Nursing Home 5313 Edmondson Ave., Balto., Md.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		20-06	
		D. STREET ADDRESS (If rural, give location) 418 Font Hill Ave. 21223			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12/10/83	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Louis Anger		14. MOTHER'S MAIDEN NAME Anna Schuckman		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. - - - -		17. INFORMANT Mr. Louis E. Ebardt 418 Font Hill Ave. 21223	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) <u>arteriosclerosis C.V.D.</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> to <u>May 29</u> 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>May 29</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. John C. Pound</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>5/30/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. J. Pound</u>		23D. ADDRESS 3325 Frederick Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/1/67		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR <u>Dr. J. Pound</u>		25C. FUNERAL DIRECTOR Howard H. Hubbard	
				ADDRESS 4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

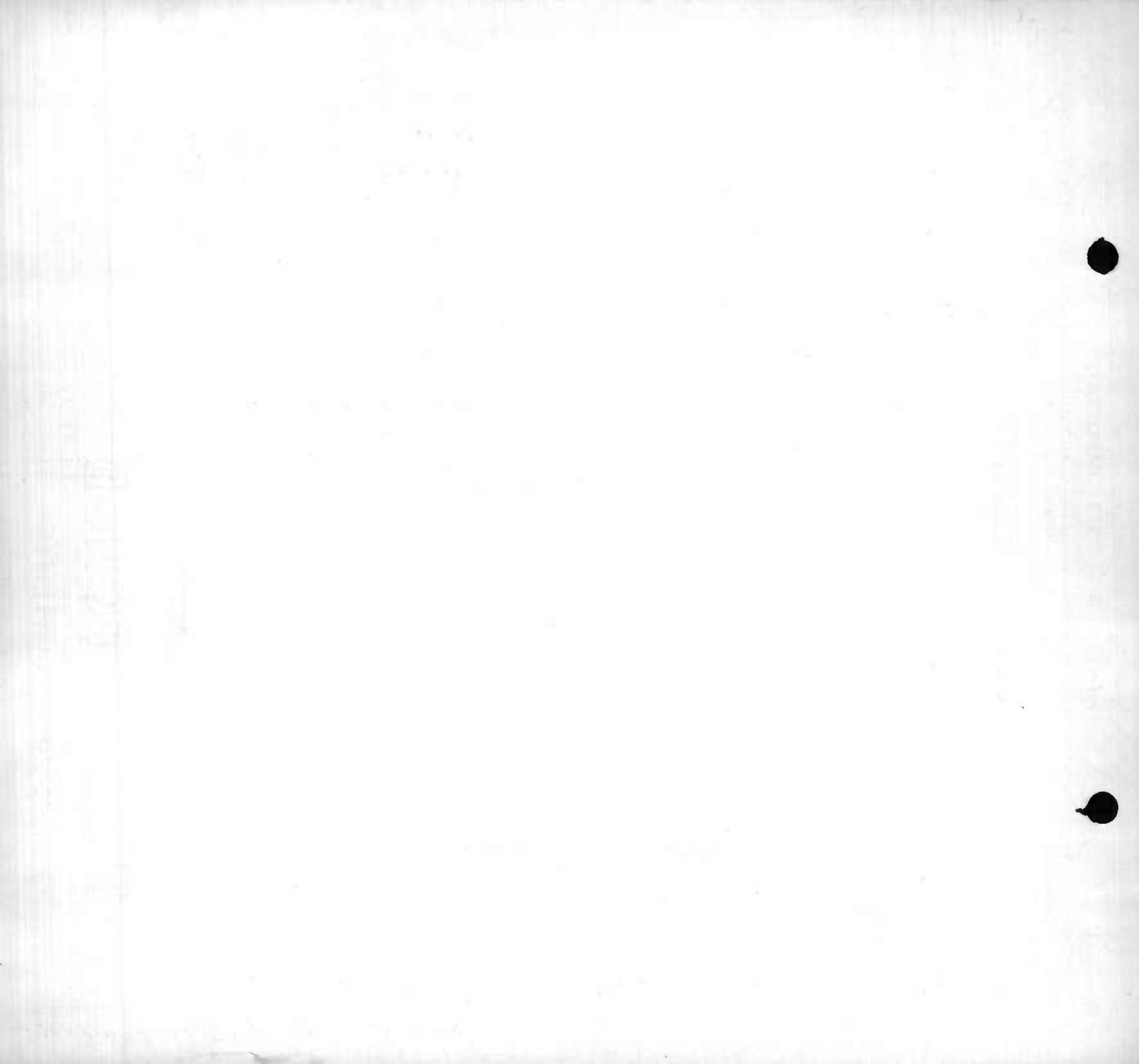
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5336					REGISTERED NO. 67 5336				
M.E. CASE NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) Robert A. Hayes					2. DATE AND HOUR OF DEATH May 30, 1967 4:00 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3200 Phelps Lane 21229					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3200 Phelps Lane				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/27/97	9. AGE (in years last birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman - retired			10B. KIND OF BUSINESS OR INDUSTRY Buck Glass		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Gabriel Hayes					14. MOTHER'S MAIDEN NAME Emma McCann				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-01-0290A		17. INFORMANT ADDRESS Mrs. Elva M. Hayes 3200 Phelps Lane 21229				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction Atherosclerotic C.D. Disease					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Hemorrhage									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3-2 19 65 to May 30 19 67 , that (I) (we) last saw the deceased alive on May 29 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John F. Schaefer					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED May 31 1967		
23C. PHYSICIAN'S NAME (Type) John F. Schaefer					23D. ADDRESS 401 Random Rd. MI4-8488				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/2/67		24C. NAME OF CEMETERY OR CREMATORY Forest Rd & Mt. Carmel Rd. Forest Baptist Church Cemetery		24D. LOCATION (City, town, or county) (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Schaefer		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 67 5337					CERTIFICATE OF DEATH					Registered No. 67 5337									
M.E. CASE NO.					1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH									
(Type or Print) Young, Eugenia.					JUN 1, 67					5.55 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY									
SINAI HOSPITAL										M.D.									
42										C. CITY OR TOWN (If outside city limits, write RURAL and give township)									
BALTO.										16-05									
D. STREET ADDRESS (If rural, give location)										2511 W. LAFAYETTE AVENUE.									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
F		W		married		1-27-11		56											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)									
School Teacher										BALTIMORE									
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME									
George A. FRANCIS										ERVA M. PUTNELL									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS									
No										RAYMOND YOUNG 2511 W. LAFAYETTE AVE.									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)										(A) Carcinoma of colon metastatic.					1 year				
ANTECEDENT CAUSES										(B)									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C)									
II										ASCUD.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
MAY 22, 67					Intestinal obstruction					-					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR?					(If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?									
(Month) (Day) (Year) (Hour)					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>														
22. I certify that (I) (this hospital) attended the deceased from 5-13 1967 to 6-1 1967, that (I) (we) last saw the deceased alive on 6-1-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE										23B. DATE SIGNED									
Francisca Sauer										6-1-67									
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS									
Sinai Hospital										14-0									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
BURIAL					6/5/67					BALTO. NATIONAL					5501 Frederick Ave				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR					ADDRESS				
JUN 5 1967					Robert E. Taylor					Joseph A. Lock					1301 N. Central Ave				



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5338

BIRTH NO. 67 5338

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

6-2-67

8:15 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2118 Druid Hill Avenue 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

3/1/25

9. AGE (In years
last birthday)

42

10. If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

George R Hawkins

14. MOTHER'S MAIDEN NAME

Hattie Casey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W W 2

16. SOCIAL
SECURITY NO.

220-18-3621

17. INFORMANT

ADDRESS

Mrs Hattie Hawkins, same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Acute subdural hematoma
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2100 Block of Division Street 14-03

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 1 '67 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Assaulted and beaten

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-2-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/7/67

23C. NAME OF CEMETERY or CREMATORY

Mt AUBURN CEMETERY

23D. LOCATION

(City, town, or county)

Baltimore Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

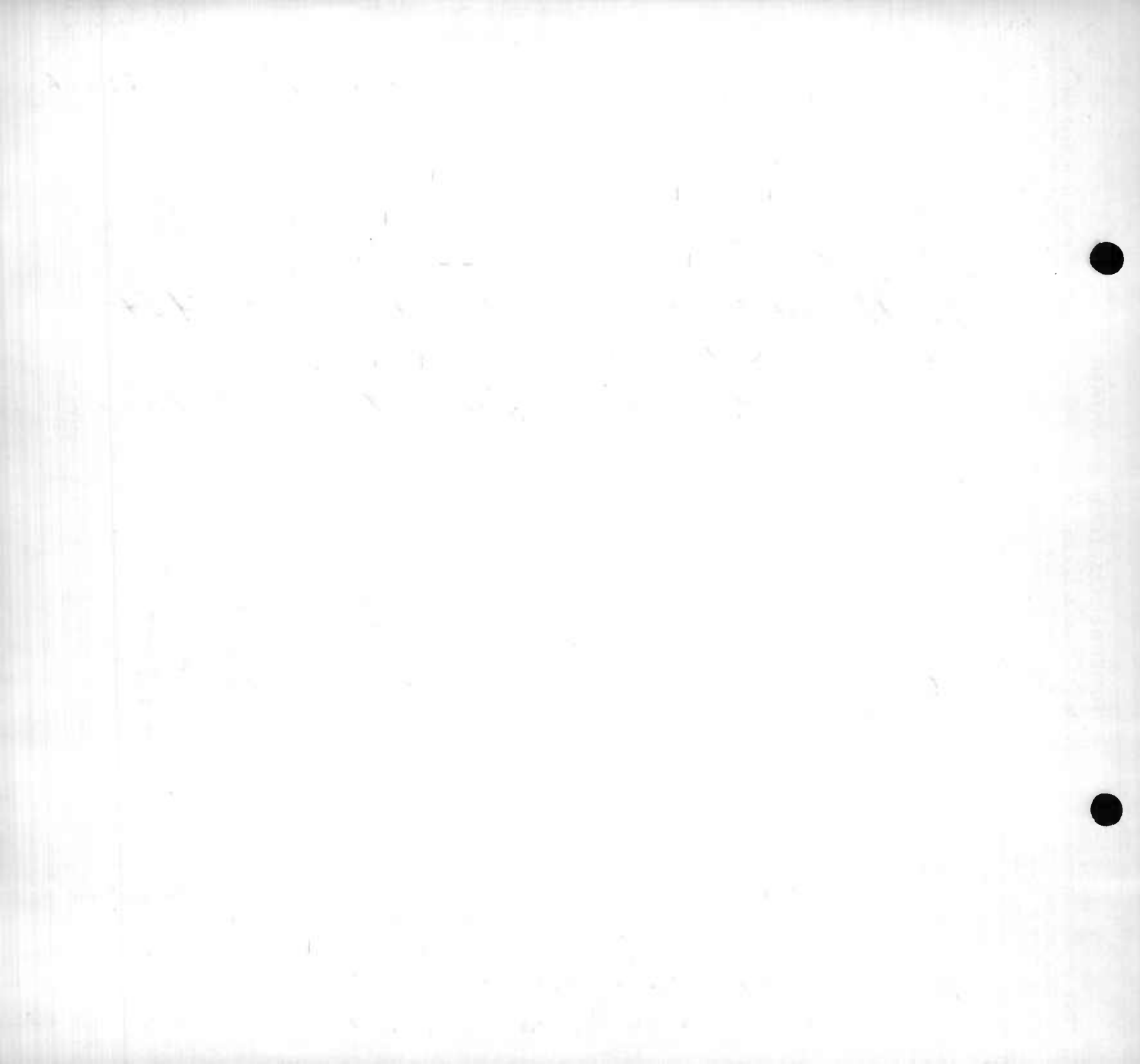
ADDRESS

Adolphus Halstead 1206 W North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

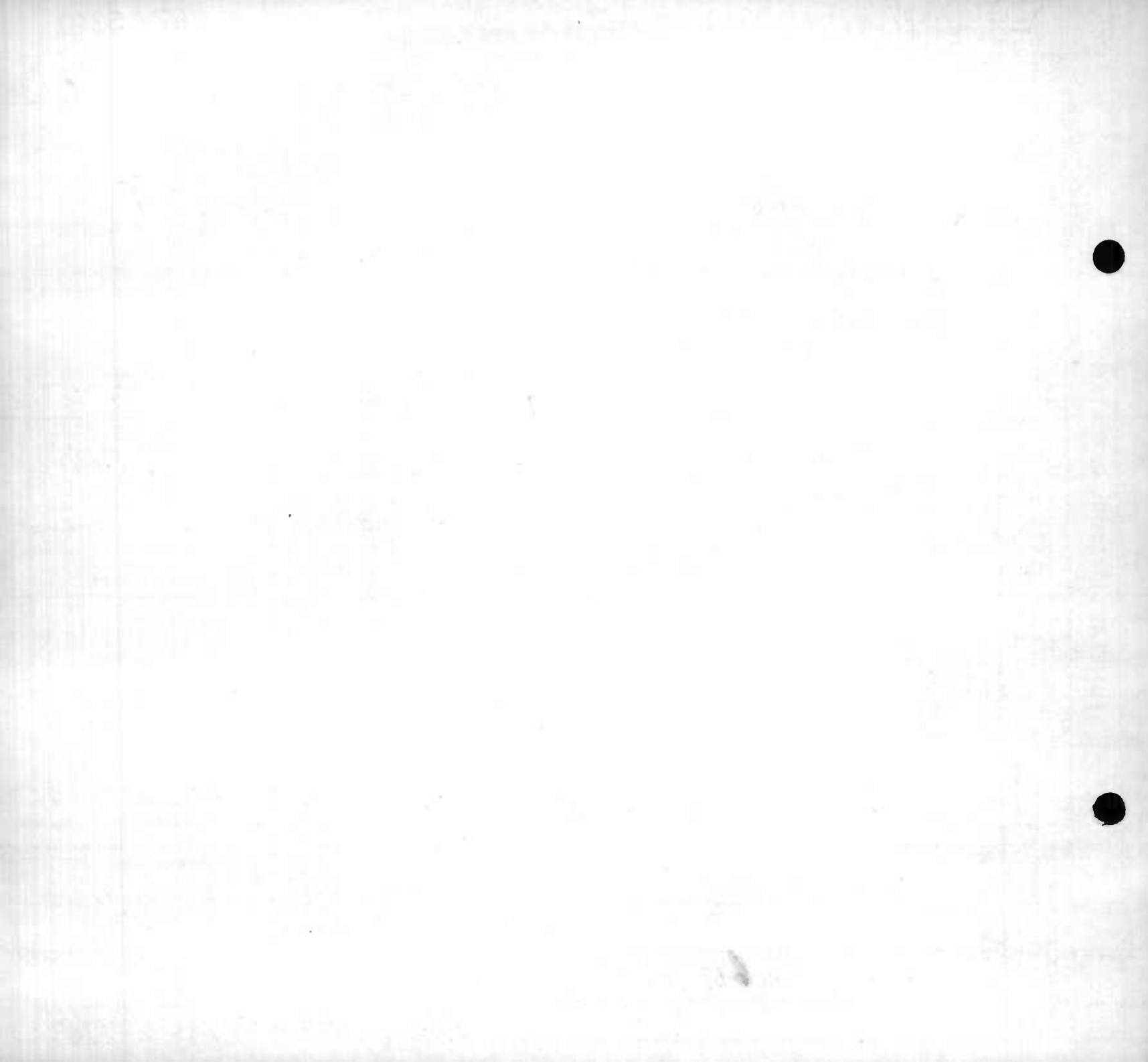
BIRTH NO. 67 5339		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5339	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) <i>Andrew Medley</i>	
2. DATE AND HOUR OF DEATH <i>June 2 - 1967 8:20 A.M.</i>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>X</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i> <i>33</i>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>	
				D. STREET ADDRESS (If rural, give location) <i>125 COLVIN STREET</i>	
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>4-1-91</i>	9. AGE (In years last birthday) <i>76 25</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RET MUSICIAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>CHURCH</i>		11. BIRTHPLACE (State or foreign country) <i>NOVA SCOTIA - VA.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>ANDREW J. MEDLEY JR</i>		14. MOTHER'S MAIDEN NAME <i>MAMIE LISCOMB</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WWI</i>		16. SOCIAL SECURITY NO. <i>216-32-7174</i>		17. INFORMANT <i>FRANCIS MEDLEY</i>	
18. ADDRESS <i>1630 N. SPALDING</i>		19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i>		(A) DUE TO			
B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Coma</i>		(B) DUE TO			
C. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cardiac Arrest</i>		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>5/26 1967</i> to <i>6/2 1967</i> , that (1) (we) last saw the deceased alive on <i>6/2 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>R. Rampton</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6/2/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>RALPH RAMPTON</i>		23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-7-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTO NATIONAL</i>	
24D. LOCATION <i>BALTO MD</i>		24E. NAME OF REGISTRAR <i>John E. Taylor</i>		24F. FUNERAL DIRECTOR <i>Franklin B. Taylor</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1967</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <i>638 N. E. ... St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

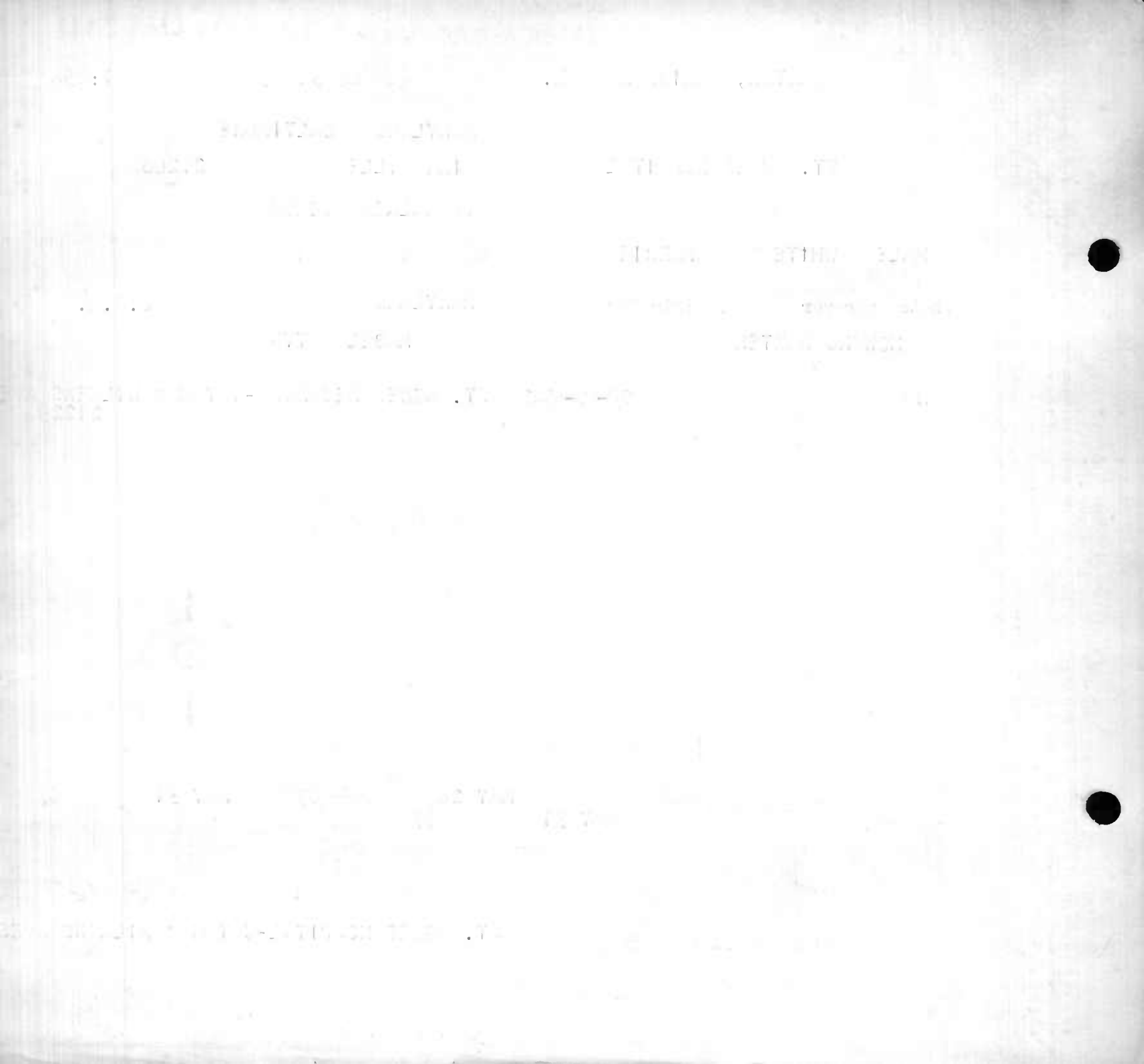
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5340</u>	
67 5340				BIRTH NO.	
M.E. CASE NO.				1. NAME OF DECEASED	
(Type or Print)				2. DATE AND HOUR OF DEATH	
JUSTINE A. BRAKE				JUNE 2-1967 11:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
36 Franklin Sq. Hospital				MD BALTIMORE 19-03	
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH 9. AGE (In years last birthday)	
Fem WH Widowed				Aug 6-1917 49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
BERNARD RUHL				JACOB	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO NO				212-10-6762	
17. INFORMANT				ADDRESS	
MRS Regina White				924 DALTEN AVE	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) DUE TO	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cor Pulmonale Sudden	
ANTECEDENT CAUSES				(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Pulmonary Emphysema 3 years	
(C) _____				_____	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0		_____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		_____	
22. I certify that (I) (this hospital) attended the deceased from 3/20 1967 to 6/2 1967, that (I) (we) last saw the deceased alive on 5/22/ 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John P. Urlock Jr.				6/3/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
1727 JOHN P. URLOCK JR.				1227 Washington Blvd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		June 6-67		BALTO NATL Cem	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.			
BALTO - MD		JUN 5 1967			
25A. NAME OF REGISTRAR		25B. FUNERAL DIRECTOR		ADDRESS	
E. E. F. F.		THOMAS J. KENNY JR.		1600 Hollers	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5341	
BIRTH NO. 67 5341		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WAXTER, RICHARD H.		2. DATE AND HOUR OF DEATH 05 31 67 1:45A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) PIKEVILLE 21208 53-00 D. STREET ADDRESS (If rural, give location) 16 WALKER AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 08 07 18	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo engraver		10B. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HOWARD WAXTER		14. MOTHER'S MAIDEN NAME MABEL WATTS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-07-8343		17. INFORMANT ADDRESS ST. AGNES RECORDS - CATON & WILKENS AVE 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 287X1		CAUSE OF DEATH (A) LEFT VENTRICULAR dilatation and HYPERTROPHY DUE TO (B) Multiple Pulmonary embolism DUE TO (C) Obesity			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from MAY 26 19 67 to MAY 31 19 67 , that (H) (we) last saw the deceased alive on MAY 31 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Federico Pollicina</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/31/67	
23C. PHYSICIAN'S NAME (Type) FEDERICO POLLICINA		23D. ADDRESS M.D. ST. AGNES HOSPITAL-CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/2/67		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikeville Balto. Md		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			
25B. NAME OF REGISTRAR Dr. E. J. Fadden		25C. FUNERAL DIRECTOR Spring B. Rogers			
25D. ADDRESS 8728 Liberty Rd Randalltown Md					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO.		67 5342		CERTIFICATE OF DEATH			Registered No. 67 5342		
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) Robert C. Jones			2. DATE AND HOUR OF DEATH 5-31-67 11 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 49 North Charles Horn.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Owings Mills 53-00 D. STREET ADDRESS (If rural, give location) Painter's Mill Rd.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 3-11-77	9. AGE (In years last birthday) 90 yrs	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY DAN GARY PUBLISHING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Zora Jones				14. MOTHER'S MAIDEN NAME (unknown)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-32-7967		17. INFORMANT North Charles General Hospital			ADDRESS		
18. 531X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CVA (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5-27-1967 to 5-31-1967, that (I) (we) last saw the deceased alive on 5-31-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE F. Abban				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-31-67			
23C. PHYSICIAN'S NAME (Type) Jerome Gaber				23D. ADDRESS 5806 Bellona Ave. #21212					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 3, 1967		24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) Pikesville Balto Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Loring Byers		25D. ADDRESS 8728 Liberty Road Randallstown, Md. 21133			

MEMORANDUM FOR THE DIRECTOR

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

TO: [Illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5343	
BIRTH NO. 67 5343		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Emory Franklin Wagner</i>		2. DATE AND HOUR OF DEATH <i>6/2/67 11 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>R.F.D. 4</i> B. COUNTY <i>Carroll Co.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 University Hospital Lombard & Bruce Sts.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Westminister</i> D. STREET ADDRESS (If rural, give location) <i>md. 56-00</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single SEPARATED</i>	8. DATE OF BIRTH <i>10/22/20</i>	9. AGE (in years, last birthday) <i>46</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Custodian</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>School</i>		11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Clarence Wagner</i>		14. MOTHER'S MAIDEN NAME <i>Grace Wagner</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes U.W.I.</i>		16. SOCIAL SECURITY NO. <i>219-05-0995</i>		17. INFORMANT <i>Mr Clarence Wagner</i>	
18. <i>15-1X-1008-1</i>		CAUSE OF DEATH		ADDRESS <i>Westminister RTHy 2nd.</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) <i>Cardiac arrest</i> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Ca stomach = extension to esophagus</i> DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>The</i>			
19A. DATE OF OPERATION <i>5/10/67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca stomach</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/6 1967</i> to <i>6/2 1967</i> , that (I) (we) lost saw the deceased alive on <i>6/2 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William A. Seovill M.D.</i>				23B. DATE SIGNED <i>6/3/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>William A. Seovill</i>		23D. ADDRESS <i>University of Maryland Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/5/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Lake View Mem. Gardens</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1967</i>			
25B. NAME OF REGISTRAR <i>Dr. J. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>J. E. Taylor</i>		ADDRESS <i>Westminister, Md.</i>	

67 5344

BALTIMORE CITY HEALTH DEPARTMENT

67 5344

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)CLINE
ELI T. KLINE

2. DATE AND HOUR PRONOUNCED DEAD

6-2-67

12:40 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

908 LEMMON STREET - Amb. Crew #5

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

908 Lemmon Street 21223

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Dec 2, 1913

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sanitation Dept

10B. KIND OF BUSINESS OR INDUSTRY

City Employee

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Leroy Cline

14. MOTHER'S MAIDEN NAME

Mollie W. ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

P

17. INFORMANT

ADDRESS

Margaret Stanton 318 S. Packer St. (21201)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary embolus - complicating
DUE TO
XXXXXX

fractures of right tibia and fibula

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Monroe Street - 24' South of

Lombard Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
4 3 '67 1:30 PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Jumped off truck

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-2-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/5/67

23C. NAME OF CEMETERY or CREMATORY

Landon Park Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUN 5 1967

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

John J. Brown, Jr. 901 Hallway St.

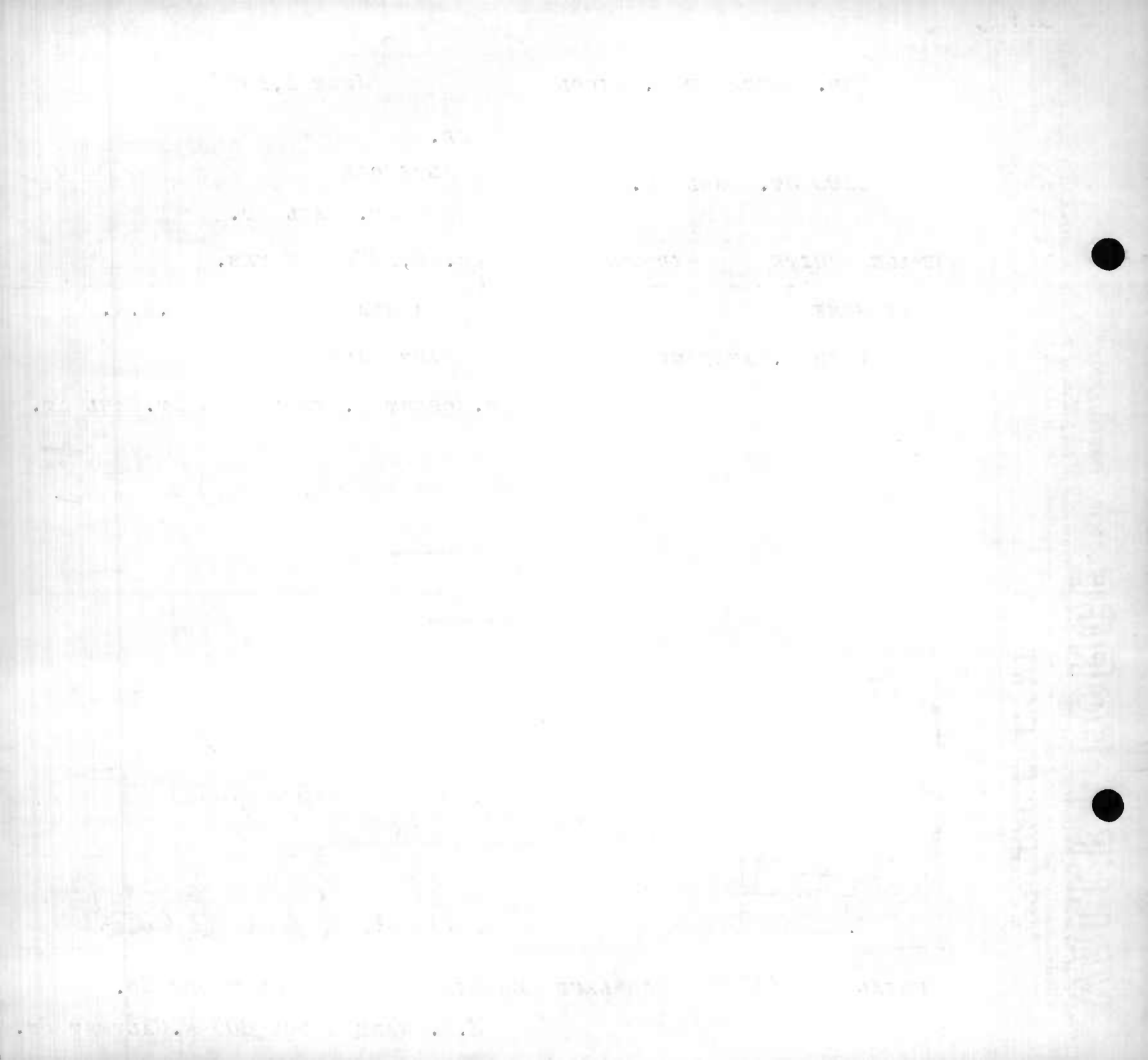
ADDRESS

Baltimore 21223

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5345	
BIRTH NO. 67 5345		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS. MARGARET E. NICOL		2. DATE AND HOUR OF DEATH JUNE 1, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3100 St. PAUL St.		A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-02 D. STREET ADDRESS (If rural, give location) 3100 St. PAUL St.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH DEC. 15, 1879	9. AGE (In years last birthday) 87 YRS.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CANADA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARTHUR P. KAVANAGH		14. MOTHER'S MAIDEN NAME MARY MADDEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. ROBERT M. NICOL 3100 St. PAUL St.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 20 minutes Arteriosclerosis (generalized) 4 years		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 8, 1963 to June 1, 1967 , that (I) (we) last saw the deceased alive on April 23, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Grafton Hersperger M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED June 1, 1967	
23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger				23D. ADDRESS 214 Medical Medical Bldg	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/3/67		24C. NAME of CEMETERY or CREMATORY MORELAND MEMORIAL	
24D. LOCATION (City, town, or county) (State) BALTIMORE Co.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			
25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR H. W. MEARS & SON 805 N. CALVERT ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was **CONWAY, Raymond A.** on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 500 67 5346		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5346	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Conway, Raymond, A.		2. DATE AND HOUR OF DEATH 5-28-67 7:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-09 D. STREET ADDRESS (If rural, give location) 4403 LOCH RAVEN BOULAVARD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 7-10-97	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT		10B. KIND OF BUSINESS OR INDUSTRY W.A. CONWAY INC. SHEET METAL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME WILLIAM A. CONWAY		14. MOTHER'S MAIDEN NAME HANNA (McCABE) McCABE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. ONE		16. SOCIAL SECURITY NO. 216-01-0838A		17. INFORMANT ADDRESS C.L. CONWAY 4403 LOCH RAVEN BLVD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I Cardiovascular collapse. 1 day. II Other significant conditions contributing to the death but not related to the disease or condition causing it. Chronic myelocytic leukemia - 1 year.		INTERVAL BETWEEN ONSET AND DEATH 1 day.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/28 1967 to 5/28 1967 , that (I) (we) last saw the deceased alive on 5/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Terry Ersel Gagon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/28/67	
23C. PHYSICIAN'S NAME (Print) TERRY ERSEL GAGON		23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/1/67		24C. NAME OF CEMETERY or CREMATORY CATHEDRAL	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS H.W. MEARS & SON 805 N. CALVERT ST.			

1941-1942
1941-1942

THE UNIVERSITY OF CHICAGO

IN THE DEPARTMENT OF

THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO

Chicago, Illinois
Chicago, Illinois
Chicago, Illinois

2/22/42
2/22/42
2/22/42

Chicago, Illinois
Chicago, Illinois

THE UNIVERSITY OF CHICAGO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5347				X CERTIFICATE OF DEATH		Registered No. 67 5347	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) DORGAN, EDNA MARIE		2. DATE AND HOUR OF DEATH 12:50 pm, June 1, 1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital		(If not in hospital or institution, give street address or location)		A. STATE Penna.		B. COUNTY York	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Delta		V-35	
				D. STREET ADDRESS (If rural, give location) Box 27			
5. SEX F	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 01-15-06	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME GEORGE M. AILES				14. MOTHER'S MAIDEN NAME M. ELIZABETH AYRES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 148-01-8377		17. INFORMANT John J. Dorgan		ADDRESS SAME	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Corrigestive heart failure. DUE TO Diabetes Mellitus. (B) ASCVD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 1:15 pm May 30 1967 to 12:50 pm June 1 1967 , that (I) (<u>we</u>) last saw the deceased alive on 12:50 pm June 1 1967 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death.							
23A. SIGNATURE Sang Won Song				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 1, 1967	
23C. PHYSICIAN'S NAME (Type) Sang Won Song				23D. ADDRESS M.D. Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-3-67		24C. NAME OF CEMETERY or CREMATORY SLATEVILLE		24D. LOCATION (City, town, or county) (State) DELTA, YORK CO., PA.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR ADDRESS George H. Hordine, DELTA, PA.			

11-11-10

12-12-10

M. E. Eason

11-11-10

No

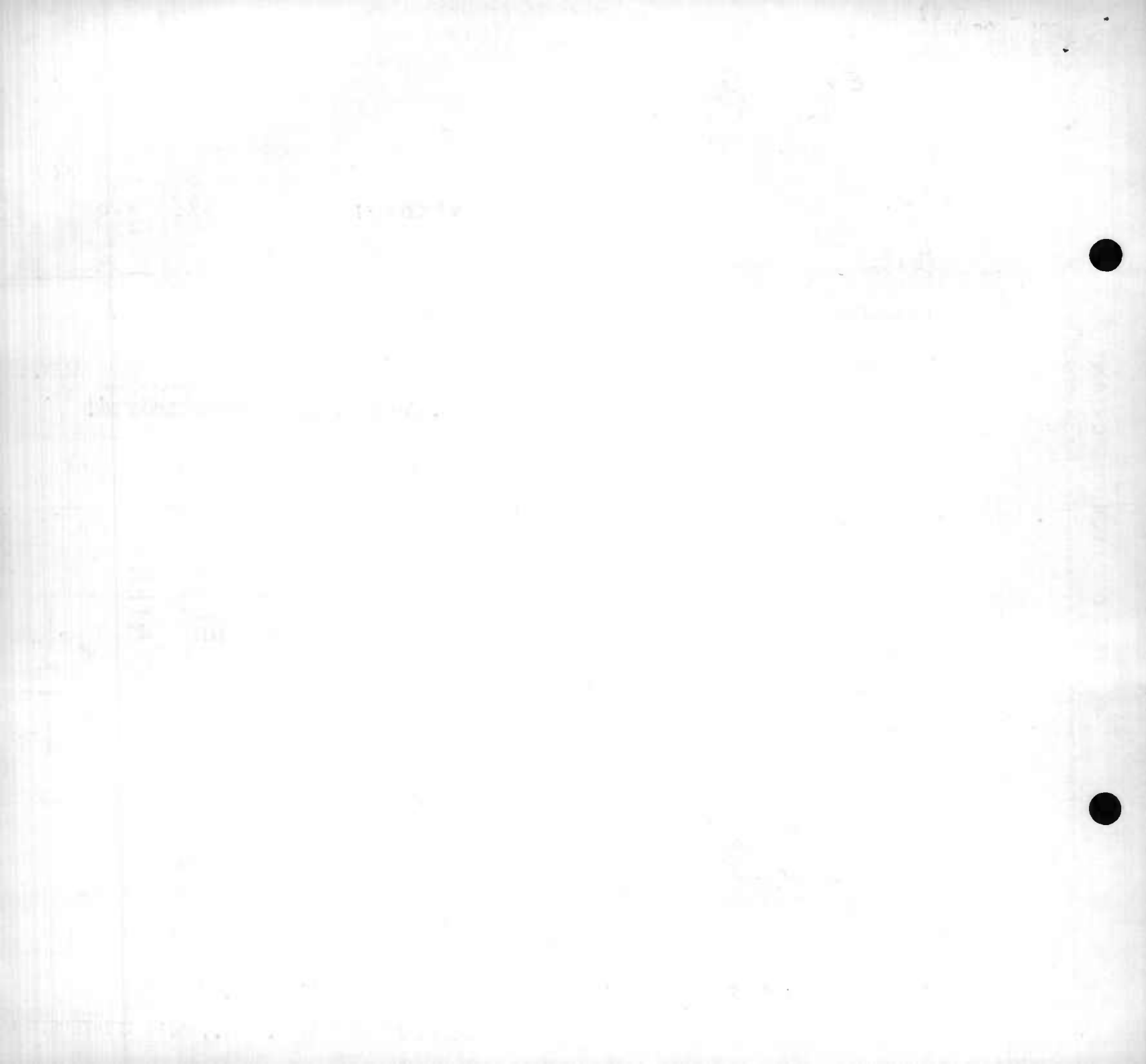
off

For the purpose of the investigation, the following information was obtained from the records of the Department of the Interior, Bureau of Land Management, Washington, D. C., on the 11th day of November, 1910.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>67 5348</u>				
BIRTH NO. <u>67 5348</u>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Eva Green</u>					2. DATE AND HOUR OF DEATH <u>May 29th 1967 4.55 P M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>Sinai Hospital of Baltimore</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY				
5. SEX <u>Female</u>					6. RACE <u>White</u>				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>					8. DATE OF BIRTH <u>2/26/89</u>				
9. AGE (In years lost birthday) <u>78</u>					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				
11. BIRTHPLACE (State or foreign country) <u>Russia</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>No</u>				
17. INFORMANT <u>Mr. Julius Tretick</u>					ADDRESS <u>ALEX. 8502 STABLE DR. VA.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Pulmonary Edema</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>					UnKnown				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Carcinoma of colour e metastases</u>					UnKnown				
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>May 29th 1967</u> to <u>4.55 P.M. 5/29 1967</u> , that (I) (we) last saw the deceased alive on <u>4.50 PM 5/29 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u>					23B. DATE SIGNED <u>5/29/67</u>				
23C. PHYSICIAN'S NAME (Type) <u>William Cieplinski</u>					23D. ADDRESS <u>Sinai Hospital of Baltimore</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>6/1/67</u>				
24C. NAME OF CEMETERY or CREMATORY <u>HEBREW YOUNG MENS</u>					24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>				
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 5 1967</u>					25B. NAME OF REGISTRAR <u>[Signature]</u>				
25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC.</u>					ADDRESS <u>6010 REISTERSTOWN</u>				



5-165 67 5349

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5349

BIRTH NO. 67 5349		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Julia Sporney		2. DATE AND HOUR OF DEATH 5-31-67 4:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE MARYLAND , B. COUNTY Baltimore	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 6824 BOSTON AVENUE #21222	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-7-98
9. AGE (In years last birthday) 68		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Char Worker		10B. KIND OF BUSINESS OR INDUSTRY Balto City	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Joseph Stanislauski		14. MOTHER'S MAIDEN NAME Michalalena Matuzak	
15. DECEASED IN U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-0944	
17. INFORMANT RECORDS: BCH 4940 Eastern Avenue		ADDRESS Baltimore, Maryland #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Artery Disease Complete Heart Block		CAUSE OF DEATH Myocardial Infarction Coronary Artery Disease Complete Heart Block	
INTERVAL BETWEEN ONSET AND DEATH acute			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 2:35 PM 5-31-67 to 4:55 PM 5-31-67 , that (1) (we) last saw the deceased alive on 5-31-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Richard L. Bishop		23B. DATE SIGNED 5-31-67	
23C. PHYSICIAN'S NAME (Type) Richard L. Bishop		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-2-67	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Walter Dabrowski		ADDRESS 1005 Dundalk Avenue	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

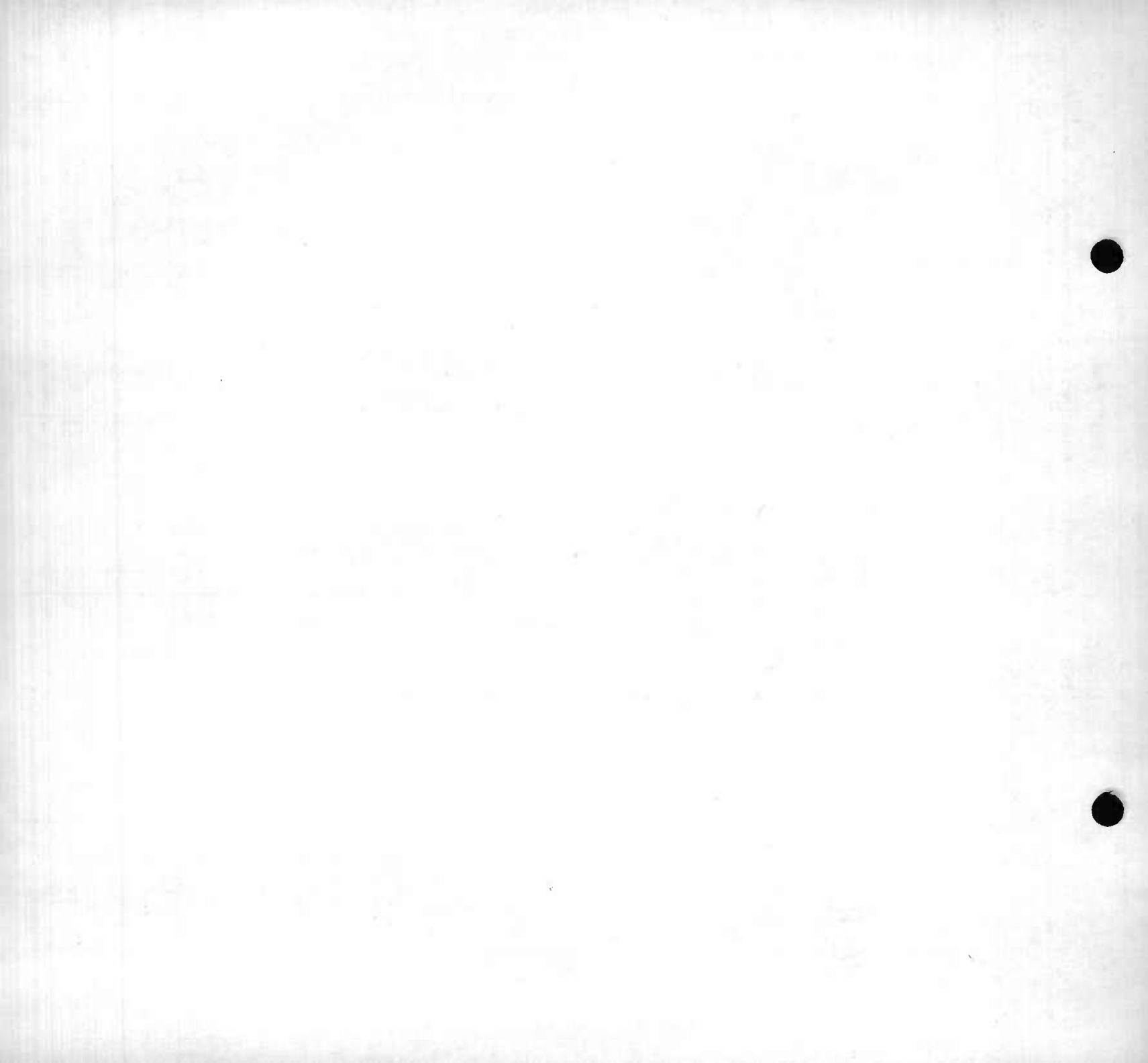
My dear Mr. [illegible]
I have just received
your letter of the 11th inst.

Yours faithfully
[illegible signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5350	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 5350</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) Mrs CATHERINE EGE</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 2 June 67 1:20 P.M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP 48</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MD B. COUNTY 8-02</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE</p> <p>D. STREET ADDRESS (If rural, give location) 1810 W GAY ST</p>		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-6-86	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME LOUIS G. SCHMIDT			14. MOTHER'S MAIDEN NAME MARGARET BIRCH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-44-3196	17. INFORMANT ADDRESS LOUISA EGE, 9111 CROSSHILL RD.		
<p>18. 420.0 I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) CARDIAC INSUFFICIENCY</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART D.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that <u>(1)</u> (this hospital) attended the deceased from 5-19-67 19 6-2 19 67, that <u>(1)</u> (we) last saw the deceased alive on 2 June 19 67 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.</p>					
23A. SIGNATURE Ramon Roig MD M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 2 June 67	
23C. PHYSICIAN'S NAME (Type) RAMON ROIG M.D.				23D. ADDRESS 701 St Paul St Balt MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/5/67	24C. NAME of CEMETERY or CREMATORY LOUPIN PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR R. E. F. J. J.		25C. FUNERAL DIRECTOR ADDRESS ILLUMINATING FUNERAL HOME 4210 BELAIR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5351					Registered No. 67 5351				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) Suoma H. Kolstrom					2. DATE AND HOUR OF DEATH June 1, 1967 5:30 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Co.				
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO - Dundalk 53-00				
(If not in hospital or institution, give street address or location)					D. STREET ADDRESS (If rural, give location) 816 S. 50th St				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/14/18	9. AGE (In years last birthday) 48	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Law Firm		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Peter Paasimaa					14. MOTHER'S MAIDEN NAME Hilja ??				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 041-01-2186		17. INFORMANT (Husband) Lauri Kolstrom, 816 S. 50th St. Dundalk, Md.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Brain stem compression					INTERVAL BETWEEN ONSET AND DEATH sudden				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral edema					19. MEDICAL EXAMINER'S CASE NO. 330 X 1				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					NOT A MEDICAL EXAMINER'S CASE				
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5/31 19 67 to 6/1/67 19 67 and that (I) (we) last saw the deceased alive on 6/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. L. Paul					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 6/1/67	
23C. PHYSICIAN'S NAME (Type) R. L. PAUL					23D. ADDRESS M.D. MERCY HOSP. Balto. Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation			24B. DATE 6/3/67		24C. NAME of CEMETERY or CREMATORY Greenmount Crematorium		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.			

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

BIRTH NO.

5352

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 5352

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARY HERMAN

2. DATE AND HOUR PRONOUNCED DEAD

May 31, 1967 8:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pikesville, 53-00

D. STREET ADDRESS (If rural, give location)

Hood Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Aug. 23, 1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Telephone Operator

10B. KIND OF BUSINESS OR INDUSTRY

Apartment Bldg.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James H. Oursler

14. MOTHER'S MAIDEN NAME

Minnie Clarke

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

212-22-4370

17. INFORMANT

ADDRESS

Mr. Barry C. Herman, 911 Windsor Road.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Barbiturate intoxication
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Hood Road, Baltimore County 53-00

21D. TIME
OF INJURY
(APPROX.)5-21-67 (Day) 5-22-67 (Month) or
5-23-67 ?

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Took overdose of barbiturate

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 1, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/5/67

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 5 1967

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

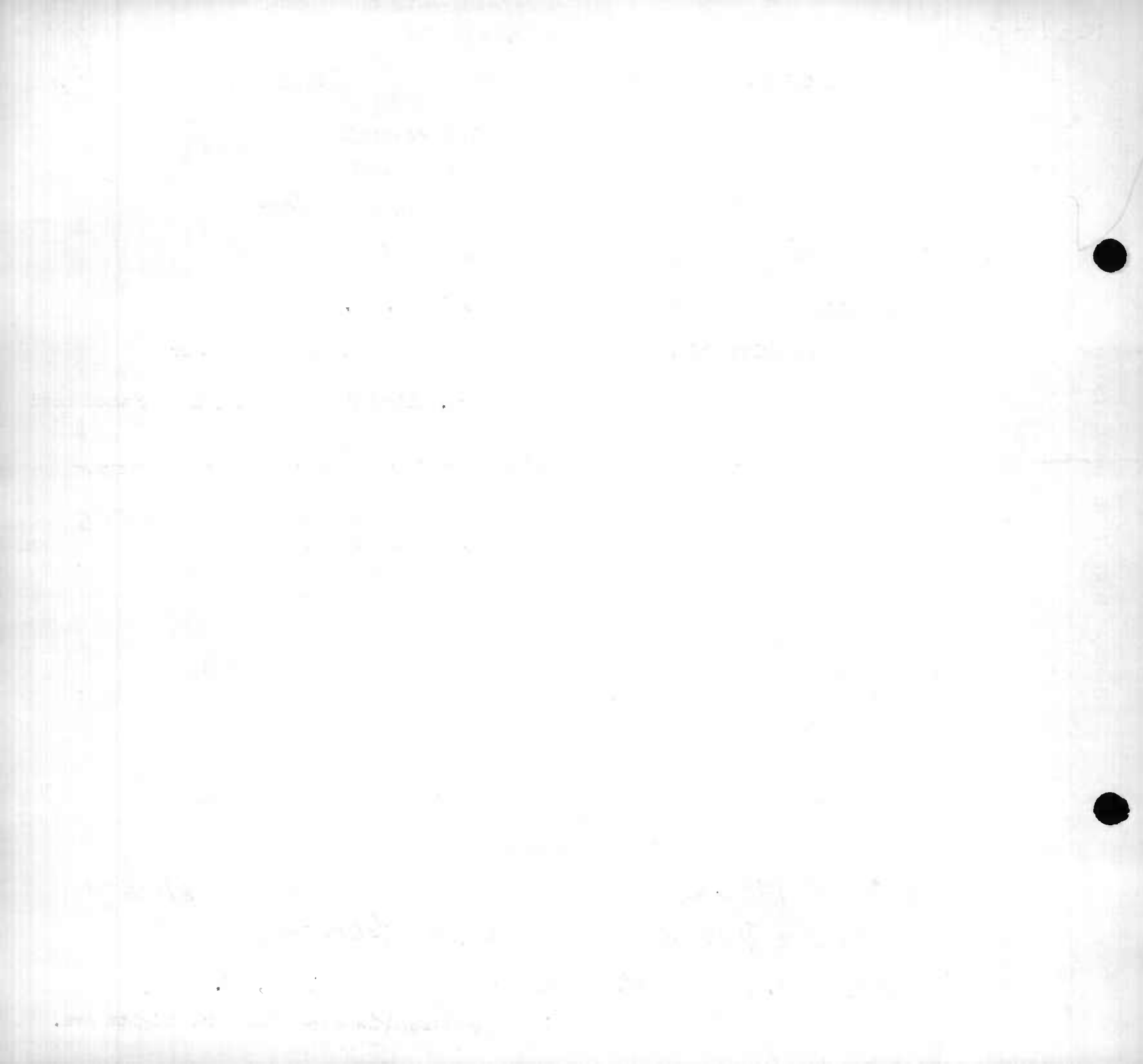
B. V. V. V. V.

ADDRESS

4611 Park Heights Ave.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>67 5353</u>	
BIRTH NO. <u>67 5353</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ROLSTON, LENA</u>	
2. DATE AND HOUR OF DEATH <u>JUNE 1, 1967</u> <u>3⁴⁰</u> <u>A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP. OF BALT.</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-16</u> D. STREET ADDRESS (If rural, give location) <u>3104 WYCLIE AVE</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WID</u>	8. DATE OF BIRTH <u>12-13-89</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) <u>77</u>
13. FATHER'S NAME <u>Frederick Thiele</u>		11. BIRTHPLACE (State of foreign country) <u>Baltimore, Md.</u>	
14. MOTHER'S MAIDEN NAME <u>Wilhelmina Hoffmyer</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Elizabeth Peacock, 5914 Yorkwood Road</u>		ADDRESS	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u> (A) DUE TO <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DIS.</u> (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <u>2⁴⁵ Am 6/1/67</u> to <u>3⁴⁰ Am 6/1 1967</u> , that he (we) lost saw the deceased alive on <u>6/1 1967</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (We) (did) did not view the body after death.			
23A. SIGNATURE <u>G. Brett Lazar</u>		23B. DATE SIGNED <u>6/1/67</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. BRETT LAZAR</u>		23D. ADDRESS <u>SINAI HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/3/67</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>	
25C. FUNERAL DIRECTOR <u>B. [Signature]</u>		ADDRESS <u>4611 Park Heights Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5354				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5354	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HARRY H. Phelan Sr.				2. DATE AND HOUR OF DEATH 5/30/67 6³⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Bolton Hill Nrsng. & Convalescent Ctr.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-13			
D. STREET ADDRESS (If rural, give location) 5509 Roland Ave							
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/31/1982	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER-OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY Shoe Store		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Jeremiah Phelan				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 084-28-1992A		17. INFORMANT ADDRESS Harry Phelan Jr. 5509 Roland Av.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 177X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. A.S.C.V.D. with old myocardial infarction 12 yrs.				INTERVAL BETWEEN ONSET AND DEATH 12 yrs. 12 yrs. 12 yrs.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) Bolton Hill N.P.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-25-1966 to May 30 1967 , that (I) (we) last saw the deceased alive on May 30, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5-30-67	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK				23D. ADDRESS M.D. 2431 Maryland Ave. Balto 21218			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/2/67	24C. NAME OF CEMETERY or CREMATORY Holly Hill Memorial Gardens		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland			
25A. DATE RECEIVED BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR E. Ellsworth Cook		25C. FUNERAL DIRECTOR ADDRESS Bruzdzinski Funeral Home 1407 Eastern Ave.			

3. 11. 1933

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5355</u>	
BIRTH NO. <u>67 5355</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>EMMA SWISTON</u>		2. DATE AND HOUR OF DEATH <u>6-1-67</u> <u>9:50</u> <u>P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>2-01</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home + Hosp</u> <u>35</u>		D. STREET ADDRESS (If rural, give location) <u>2012 Gough ST</u> <u># 31</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>12-5-02</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Cornelius Rykaczewski</u> <u>Cornelia Rykaczewska</u>		14. MOTHER'S MARRIED NAME <u>Pauline</u> <u>Pauline Kryszkiewicz</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>213-16-5863</u>		17. INFORMANT <u>Mr. Frank A. Swiston, 2012 Gough St.</u> <u>Charles</u>	
18. <u>420.141260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ante myocardial infarction</u>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes Mellitus</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-31</u> 19 <u>67</u> to <u>6-1</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-1</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6-1-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>D. A. E. SUBONG, JR.</u> M.D.				23D. ADDRESS <u>Church Home + Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/5/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Rosary</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. NAME OF CEMETERY or CREMATORY <u>Baltimore, Maryland</u>		24F. LOCATION <u>Baltimore, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 5 1967</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>M. S. SADOWSKI & SONS, 1808 EASTERN AVE</u>	

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "of" are visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "of" are visible.

Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "of" are visible.

1
C-635

67 5356

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5356

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EUGENE CURETON

2. DATE AND HOUR PRONOUNCED DEAD

May 31, 1967

11:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

14-02

D. STREET ADDRESS (If rural, give location)

1527 Shields Place

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

6/20/37

9. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labourer

10B. KIND OF BUSINESS OR INDUSTRY

contractors

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ulysses Cureton

14. MOTHER'S MAIDEN NAME

Carrie Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

216-34-1839

17. INFORMANT

ADDRESS

Carrie Robinson 1527 Shields Pl.

18.

431X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Idiopathic myocardiopathy
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 1, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/5/67

23C. NAME of CEMETERY or CREMATORY

West Liberty

23D. LOCATION

(City, town, or county)

(State)

Friendship, Howard Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 5 1967

24B. NAME OF REGISTRAR

Bob E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Chatman - 1701 Mt. Vernon St.

ADDRESS

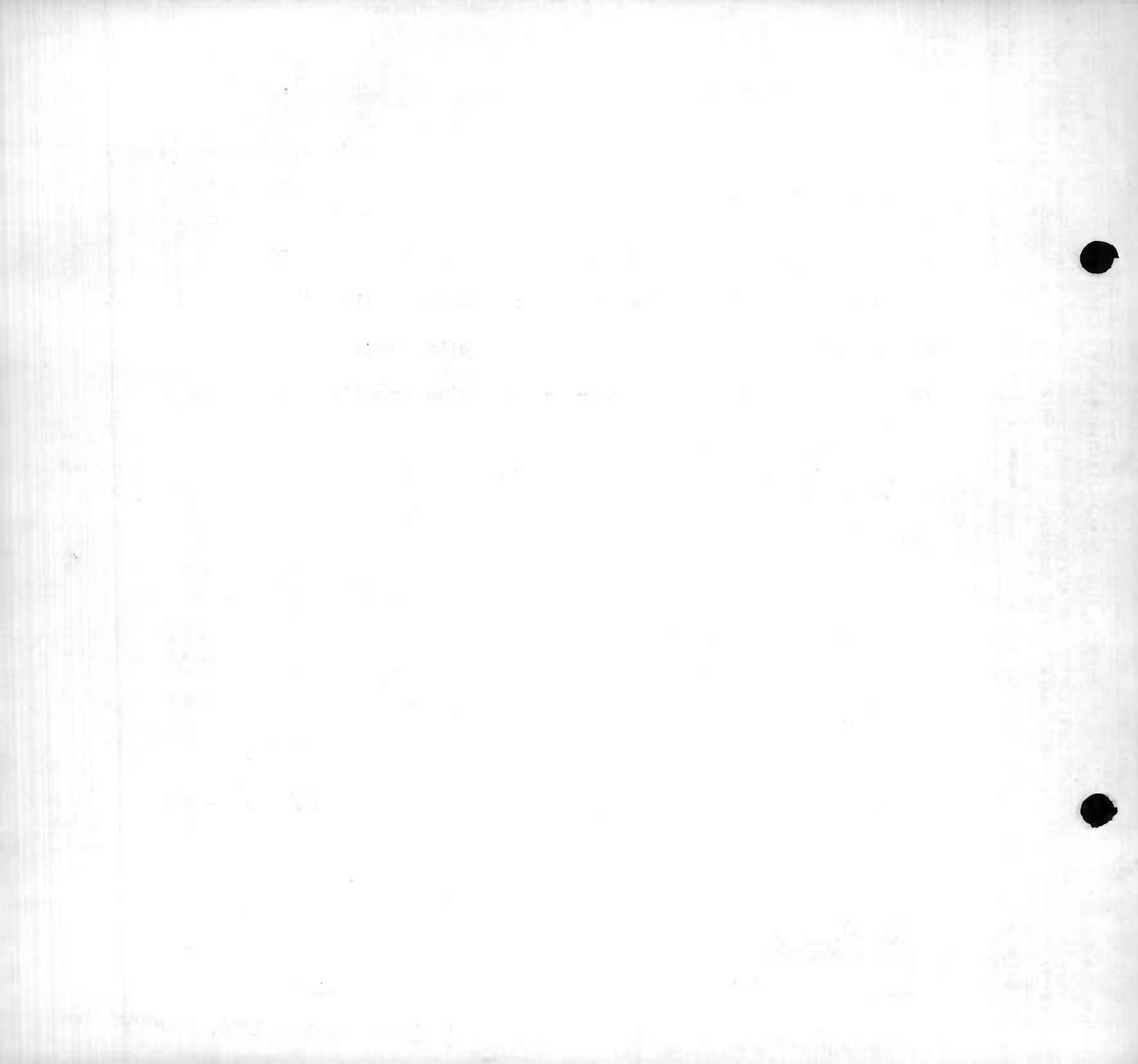
Baltimore Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5357		Registered No. 67 5357	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HOWARD E JONES				2. DATE AND HOUR OF DEATH JUNE 1, 1967			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND 90 Kenesaw Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2202 Brookfield Ave			
5. SEX M F		6. RACE C C		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH 5/8/16	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10B. KIND OF BUSINESS OR INDUSTRY Dupont Chemicals		9. AGE (In years last birthday) 50		11. BIRTHPLACE (State or foreign country) Chatham Virginia	
13. FATHER'S NAME Robert Jones				12. CITIZEN OF WHAT COUNTRY? U S A			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) yes W W 2		16. SOCIAL SECURITY NO. 530-05-2856		17. INFORMANT Miss Ernestine Jones Same		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO Put cell carcinoma of lungs (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH about 6 mos	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 10, 1967 to June 1, 1967 , that (I) (we) last saw the deceased alive on June 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Paul Byerly				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) M. Paul Byerly, M.D.				23D. ADDRESS 5820 York Road Baltimore, Md. 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67		24C. NAME of CEMETERY or CREMATORY Chatham		24D. LOCATION (City, town, or county) (State) Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Adolphus Halstead		25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206, W North Ave	

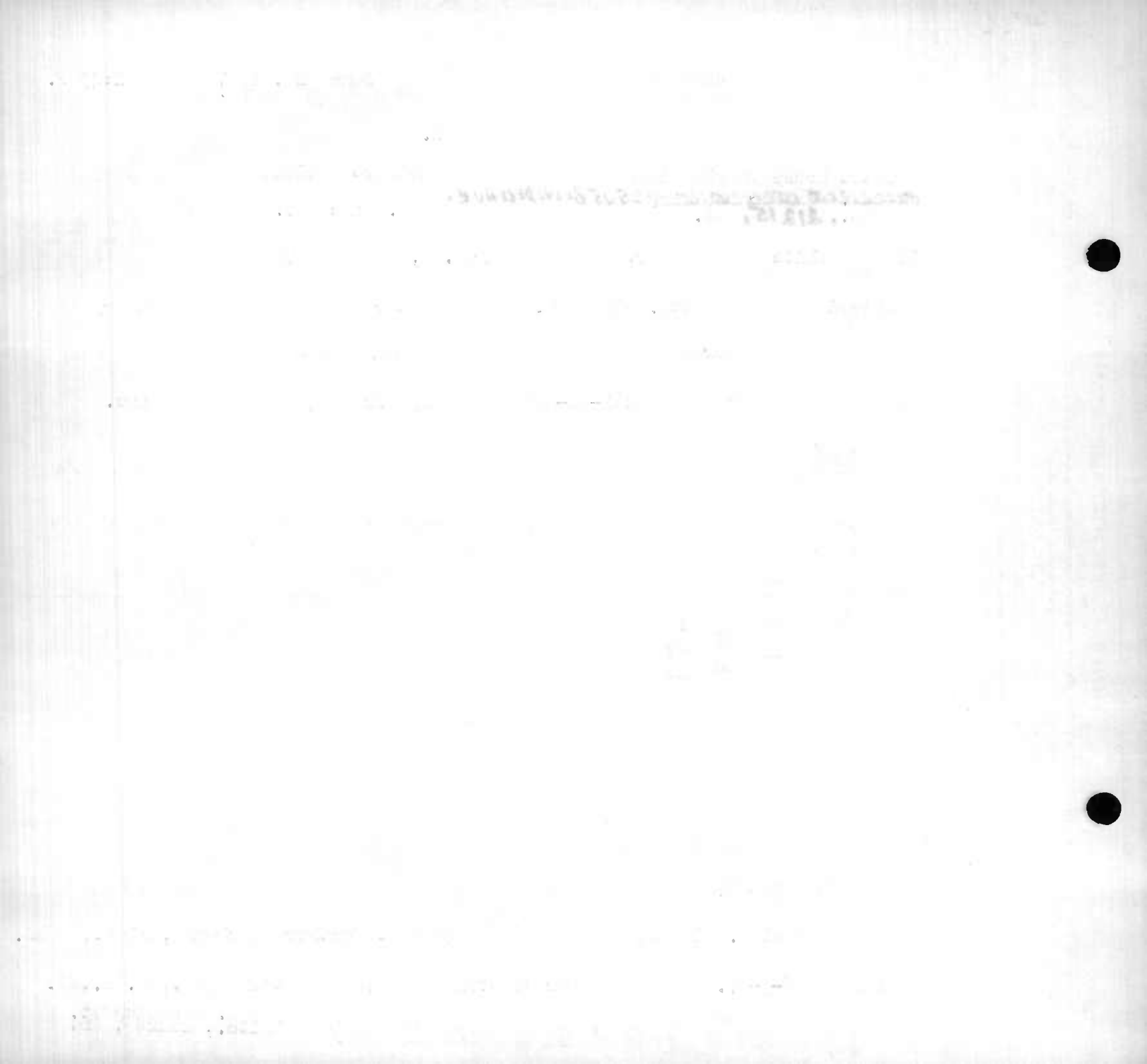
JUN 5 1967



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5358		CERTIFICATE OF DEATH		Registered No. 67 5358	
1. NAME OF DECEASED (Type or Print) JOHN HERMAN				2. DATE AND HOUR OF DEATH June 2, 1967		2:45 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Belvedere House In The Pines 4000 W. Northern Parkway, Balto., 21215, Md.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # 21224 D. STREET ADDRESS (If rural, give location) 908 S. Ponca St.					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Nov. 8, 1896	9. AGE (In years last birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? Hungary
13. FATHER'S NAME ? Herman			14. MOTHER'S MAIDEN NAME Mary Moroz			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 213-02-4210			17. INFORMANT Mary Herman (Widow)			ADDRESS Same.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized Carcinoma				CAUSE OF DEATH (A) DUE TO Generalized Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 1 month			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) DUE TO Carcinoma left lung		7 months			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/15 19 67 to 6/2 19 67 , that (I) (we) last saw the deceased alive on 6/2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Israel S. Zinberg				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/3/67			
23C. PHYSICIAN'S NAME (Type) Israel S. Zinberg				23D. ADDRESS 4000 W. Northern Parkway, Balto., Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-5-67.		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba. Co., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Robert E. Taylor		25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5359		CERTIFICATE OF DEATH		67 5359	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>Lilly M. Jackson Lillie</i>			2. DATE AND HOUR OF DEATH <i>5/31/67 6:27 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>15-04</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Univ of Maryland</i>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, MD</i>		
			D. STREET ADDRESS (If rural, give location) <i>1909 Herbert St</i>		
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widow</i>	8. DATE OF BIRTH <i>9/20/04</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>presser</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Laundry</i>	11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William Knight</i>			14. MOTHER'S MAIDEN NAME <i>Lillie Cheatum</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>107-144892</i>		17. INFORMANT ADDRESS <i>Edward Jackson Lane</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <i>150X1</i>			CAUSE OF DEATH (A) <i>Exanguination</i> DUE TO (B) <i>Ca. Esophagus</i> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>8 hrs.</i> <i>2 yrs.</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/31</i> 19 <i>67</i> to <i>5/31</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5/31</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David A. Shafritz</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>David A. Shafritz</i>				23D. ADDRESS <i>Univ of Maryland Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/3/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1967</i>			
25B. NAME OF REGISTRAR <i>W. G. S. Edwards</i>		25C. FUNERAL DIRECTOR <i>Wright & Phillips</i>		ADDRESS <i>1727 N. Mount St</i>	

511

100

10

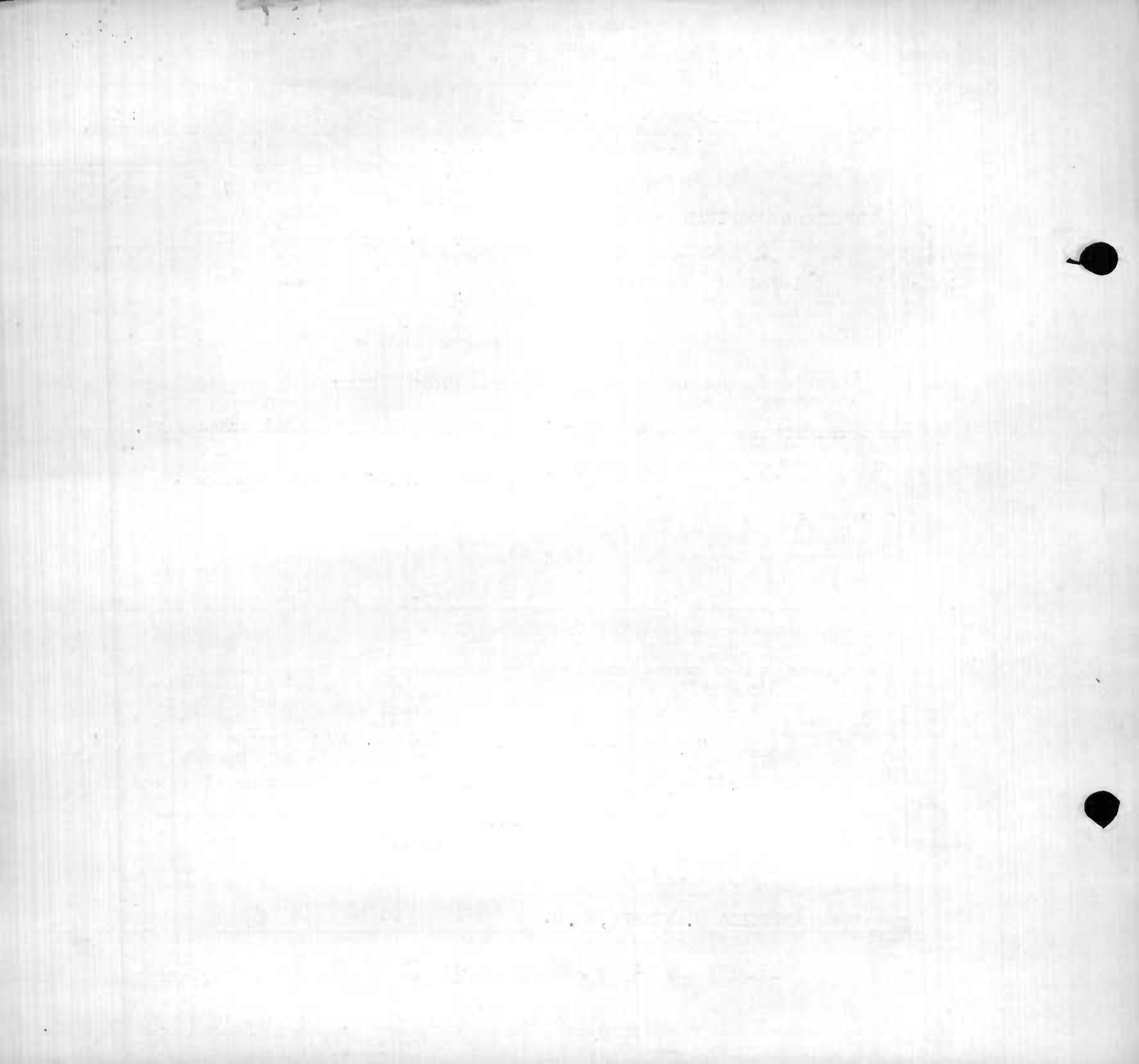
100

100

67 5360
BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5360

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) THOMAS HUNTER		2. DATE AND HOUR PRONOUNCED DEAD 5-28-67 2:45 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 46 LUTHERAN HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-06 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2857 W. North Avenue 21216	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Feb. 21, 1925
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 42
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Freeman		14. MOTHER'S MAIDEN NAME Addie Hunter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 212-20-5940	17. INFORMANT Addie Adley
18. CAUSE OF DEATH E 981 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of abdomen and chest ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2857 W. North Avenue 15-06
21D. TIME OF INJURY (APPROX.) 5 27' 11:35 PM	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Shot by wife during altercation	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE RUSSELL S. FISHER, M.D. EXAMINER'S NAME (Type)			
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-1-67	23C. NAME of CEMETERY or CREMATORY Baltimore National
23D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24A. DATE REC'D BY HEALTH DEPT. JUN 5 1967	
24B. NAME OF REGISTRAR Robert E. Fisher		24C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monroe St.	



BIRTH NO. 67 5361		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5361	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
WILLIAM A. SMITH			5-30-67 11:45 AM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
3816 BOARMAN AVENUE			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
00			D. STREET ADDRESS (If rural, give location) 3816 Boarmen Avenue 21215		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Colored	Dep.	July 17, 1925	41	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)	
Laborer				North Carolina	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unknown			Alice Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		241-30-4702		Naomi Smith 3204 Baermington	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) Laennec's cirrhosis DUE TO (B) DUE TO (C) DUE TO	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
RUSSELL S. FISHER, M.D.			ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial		6-5-67		Baltimore National	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 5 1967		Philip E. Fisher		Ashton S. Phillips 1727 N. Mount St.	

James
John
William
Robert

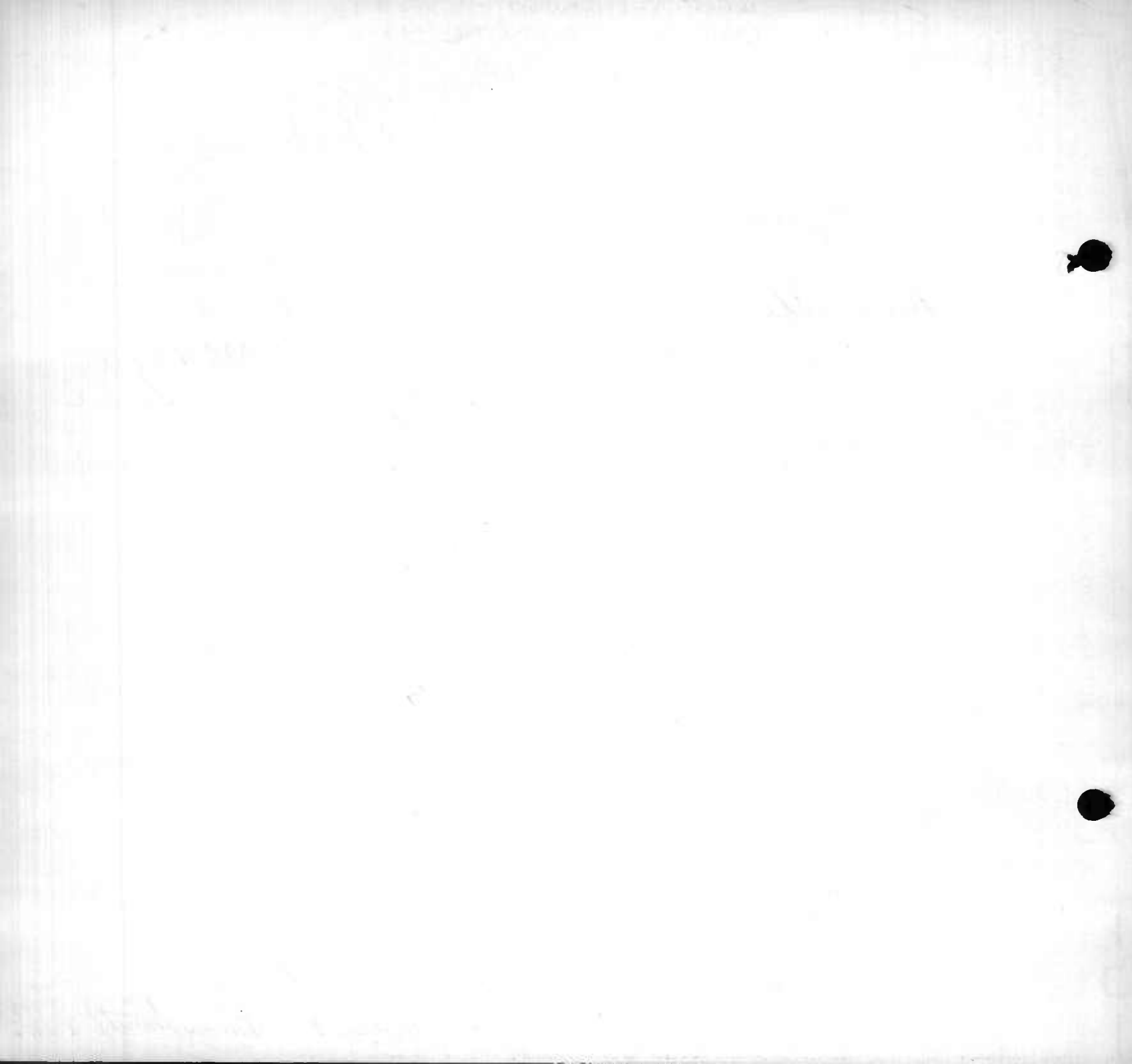
1840
1841
1842
1843
1844
1845
1846
1847
1848
1849
1850

James
John
William
Robert
1851
1852
1853
1854
1855
1856
1857
1858
1859
1860

FUNERAL DIRECTOR: IMPORTANT

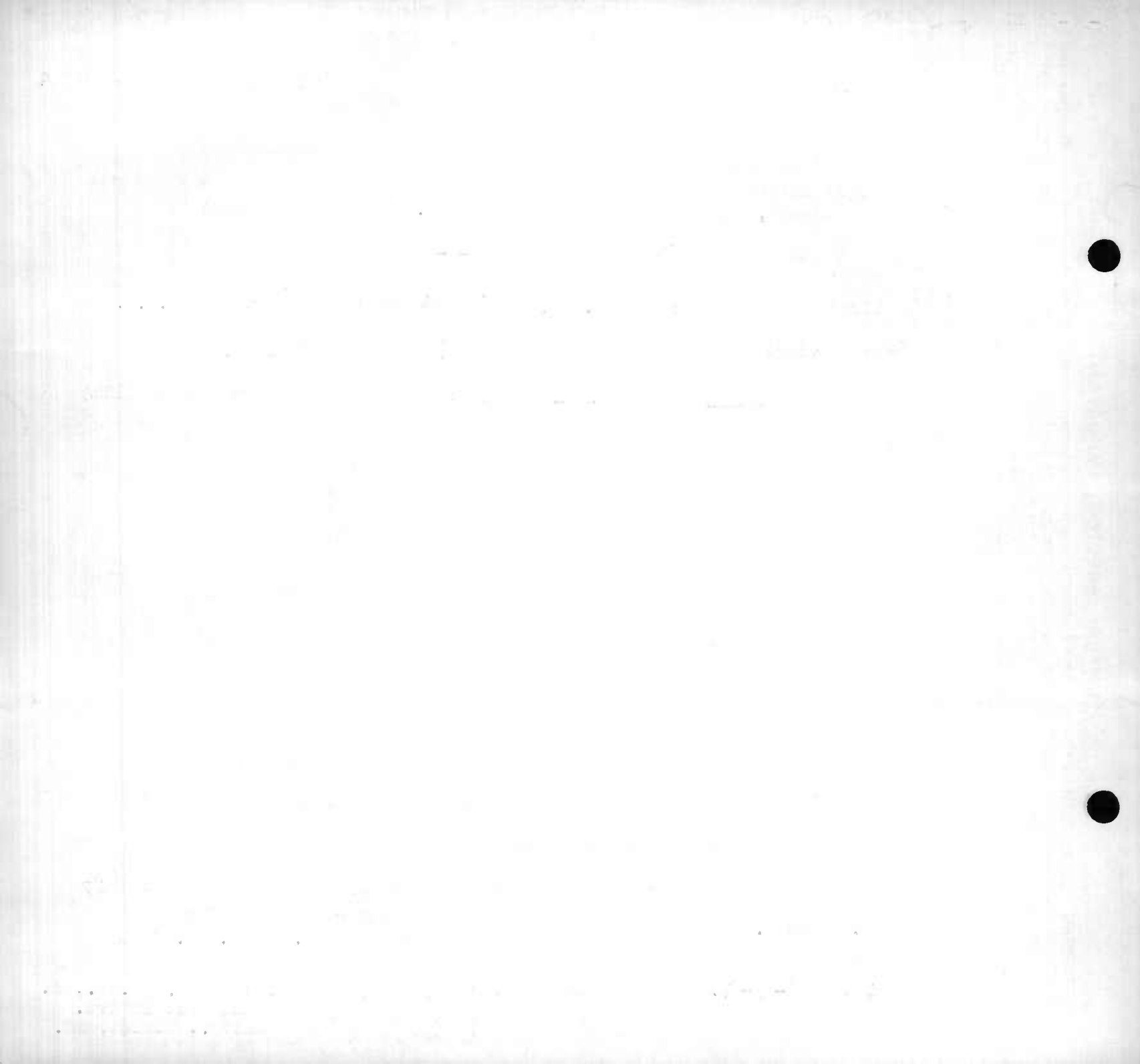
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5362	
BIRTH NO. 67 5362		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Arlene R. Smith (Rochelle)		2. DATE AND HOUR OF DEATH 6-1-67 3:42 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-04			
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp.		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21217			
5. SEX F.		6. RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 1-25-33	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10B. KIND OF BUSINESS OR INDUSTRY NONE		9. AGE (In years last birthday) 34		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Alvin Brant				14. MOTHER'S MAIDEN NAME Mamie McNeill			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Irving Smith		ADDRESS Same	
18. 430.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) acute Bacterial Endocarditis DUE TO (B) Pneumonia DUE TO (Pt was seen in terminal stage) (The sequence is presumed from history)		INTERVAL BETWEEN ONSET AND DEATH 3 wks?			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (at) (this hospital) attended the deceased from 5-31 19 67 to 6-1 19 67 , that (at) (we) last saw the deceased alive on 6-1 19 67 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.							
23A. SIGNATURE David J. Steinbauer				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-1-67	
23C. PHYSICIAN'S NAME (Type) David J. Steinbauer				23D. ADDRESS 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6-2-67		24C. NAME OF CEMETERY or CREMATORY MC Neill		24D. LOCATION (City, town, or county) (State) Smithfield N.C.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Taylor, MA		25C. FUNERAL DIRECTOR Anderson Funeral Home		ADDRESS Smithfield, N.C.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

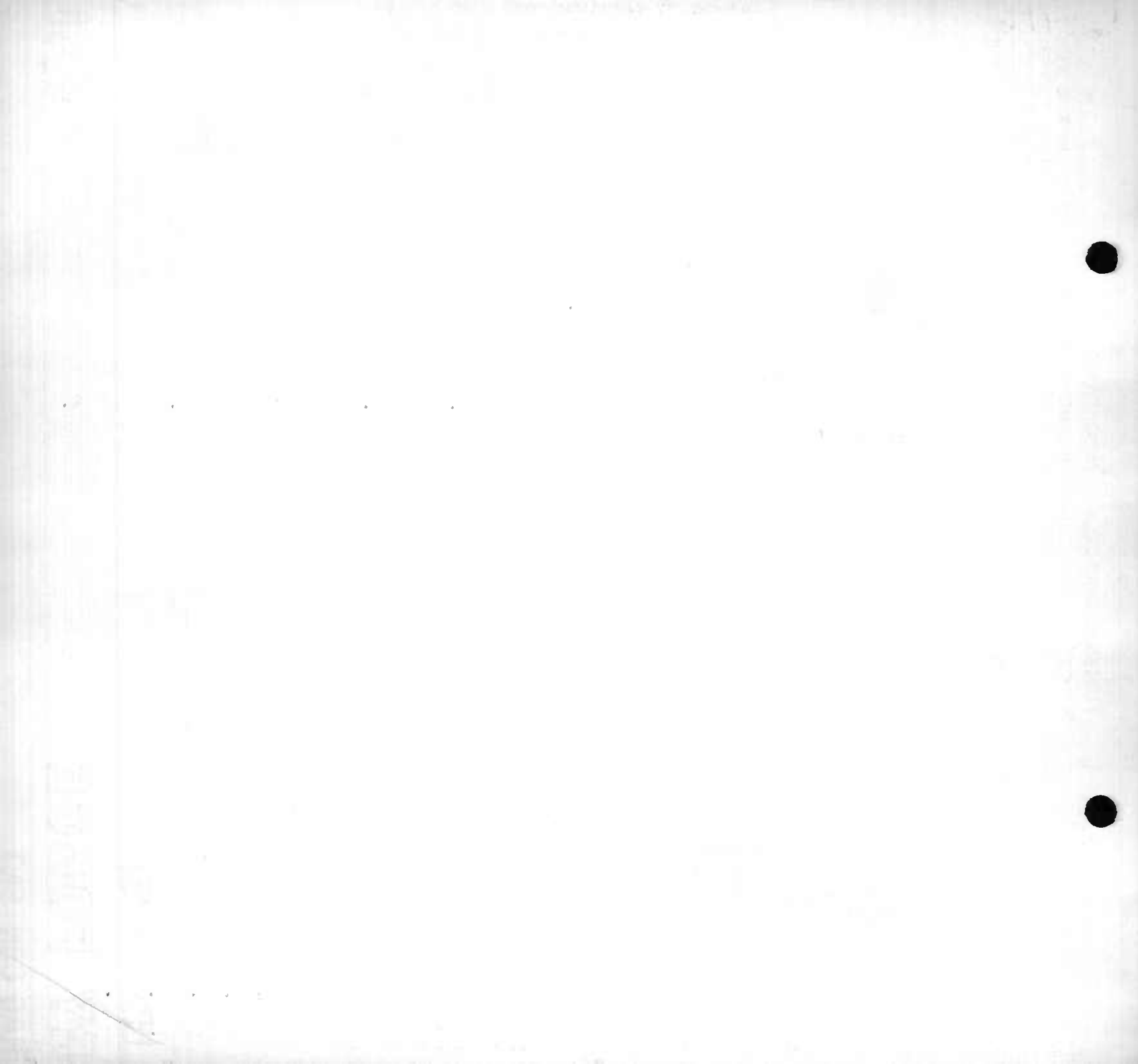
BIRTH NO. 67 5363		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5363	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIAM RAU		2. DATE AND HOUR OF DEATH 5-31-67, 6:00 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland		D. STREET ADDRESS (If rural, give location) 638 S. Oldham Street 21224		26-07	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower	8. DATE OF BIRTH 12-8-83	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Baugh Chem. Co.		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Rau		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-8453		17. INFORMANT ADDRESS BCM:Records 4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) 420.11 Myocardial Infarction		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 5-28 19 67 to 5-31 19 67 , that (H) (we) last saw the deceased alive on 5-31 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James J. Corkins		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/31/67	
23C. PHYSICIAN'S NAME (Type) Dr. James T. Corkins		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Balto. Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-3-67		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Charles J. Seiler		25D. ADDRESS 6224 Eastern Ave. Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5364	
BIRTH NO. 67 5364		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George L. Clipper		2. DATE AND HOUR OF DEATH 6/2/67 10:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital		A. STATE Maryland B. COUNTY Baltimore			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 23-02			
D. STREET ADDRESS (If rural, give location)		4 W Heath Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/3/95	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Chemical Co.		11. BIRTHPLACE (State or foreign country) Balto.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME George Clipper			
14. MOTHER'S MAIDEN NAME Sarah Ramon		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Anna D. Clipper			
ADDRESS 4 W. Heath St.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162.1 I		CAUSE OF DEATH (A) Bronchogenic Carcinoma DUE TO Embolism to chest wall (B) DUE TO (C) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II		Calcific aortic stenosis			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 5/26/67 19 to 6/2/67 19, that (he) (we) last saw the deceased alive on 6/2/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel J. Steinbauer		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/3/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 1213 Light Street Balto. Md 21230			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 6 1967		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			
25B. NAME OF REGISTRAR Albert S. Fink		25C. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5365					CERTIFICATE OF DEATH				
Registered No. 67 5365									
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>Mary F. O'Connor</i>					6/1/67 7:25 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>001023 W. Lombard St.</i>					A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>18-03</i> D. STREET ADDRESS (If rural, give location) <i>1023 W. Lombard St.</i>				
5. SEX <i>F.</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>6/14/1885</i>	9. AGE (In years last birthday) <i>81</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Dept Store</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Peter J. O'Connor</i>					14. MOTHER'S MAIDEN NAME <i>Mary E. Donohue</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>					16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Miss Ella O'Connor</i>		
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>Arteriosclerotic Heart Disease</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4 mos.</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>January 1967</i> to <i>June 1 1967</i> , that (I) was last saw the deceased alive on <i>May 29 1967</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.									
23A. SIGNATURE <i>Morris B. Schreiber</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>6-2-67</i>		
23C. PHYSICIAN'S NAME (Type) <i>MORRIS B. SCHREIBER</i>					23D. ADDRESS <i>1519 W. Lombard St Baltimore Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/5/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>4300 Old Frederick Rd.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1967</i>			25B. NAME OF REGISTRAR <i>Robert E. Talley</i>			25C. FUNERAL DIRECTOR <i>John J. Gormanston Inc.</i>			
ADDRESS <i>987 Hollins St. 23, Md.</i>									

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5366</u>	
BIRTH NO. <u>67 5366</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>KATHLEEN ANNA GEORGE</u>		2. DATE AND HOUR OF DEATH <u>1 JUNE 1967 19:20 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY of Maryland</u> <u>38 HOSPITAL</u>		A. STATE <u>md.</u> B. COUNTY <u>BALTIMORE</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>RURAL Rt. # 15 53-00</u>			
		D. STREET ADDRESS (If rural, give location) <u>Box 480</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11/20/05</u>	9. AGE (In years lost birthday) <u>61</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FEDINAND KERHNER</u>		14. MOTHER'S MAIDEN NAME <u>MARY MULLAHEY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-18-4728</u>		17. INFORMANT <u>CHART</u>	
18. <u>420.14-146X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>ACUTE MYOCARDIAL INFART - same day</u> DUE TO (B) <u></u> DUE TO (C) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CARCINOMA Nasopharynx</u>					
19A. DATE OF OPERATION <u>5-18-67</u> <u>5-28-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA NASOPHARYNX</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 16</u> 19 <u>67</u> to <u>JUNE 1</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JUNE 1</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Henry A. Jany</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1 JUNE 1967</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/5/67</u>		24C. NAME of CEMETERY or CREMATORY <u>OAK LAWN</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>B. B. ZOBKELLY</u>	
ADDRESS <u>300 MACE</u>					

1
T-550

67 5367

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 5367

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN TAYMAN

2. DATE AND HOUR PRONOUNCED DEAD

5-30-67

2:05 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Balt. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Dundalk

D. STREET ADDRESS (If rural, give location)

3400 Cornwall Road

21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-13-1923

9. AGE (In years last birthday)

44

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Shipping Supervisor E.J. Korvette

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Co. Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John A. Tayman Sr.

14. MOTHER'S MAIDEN NAME

Carrie Kohlhafer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

Army W.W.11

16. SOCIAL SECURITY NO.

217-12-3742

17. INFORMANT

Mrs Annabelle E. Tayman 3400 Cornwall Rd

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL SIGNATURE

Russell S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

5-31-67

EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6-3-1967

23C. NAME of CEMETERY or CREMATORY

Moreland Park Cemetery

23D. LOCATION (City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 5 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Lassahn Funeral Home Inc. 7401 Belair Road 21236

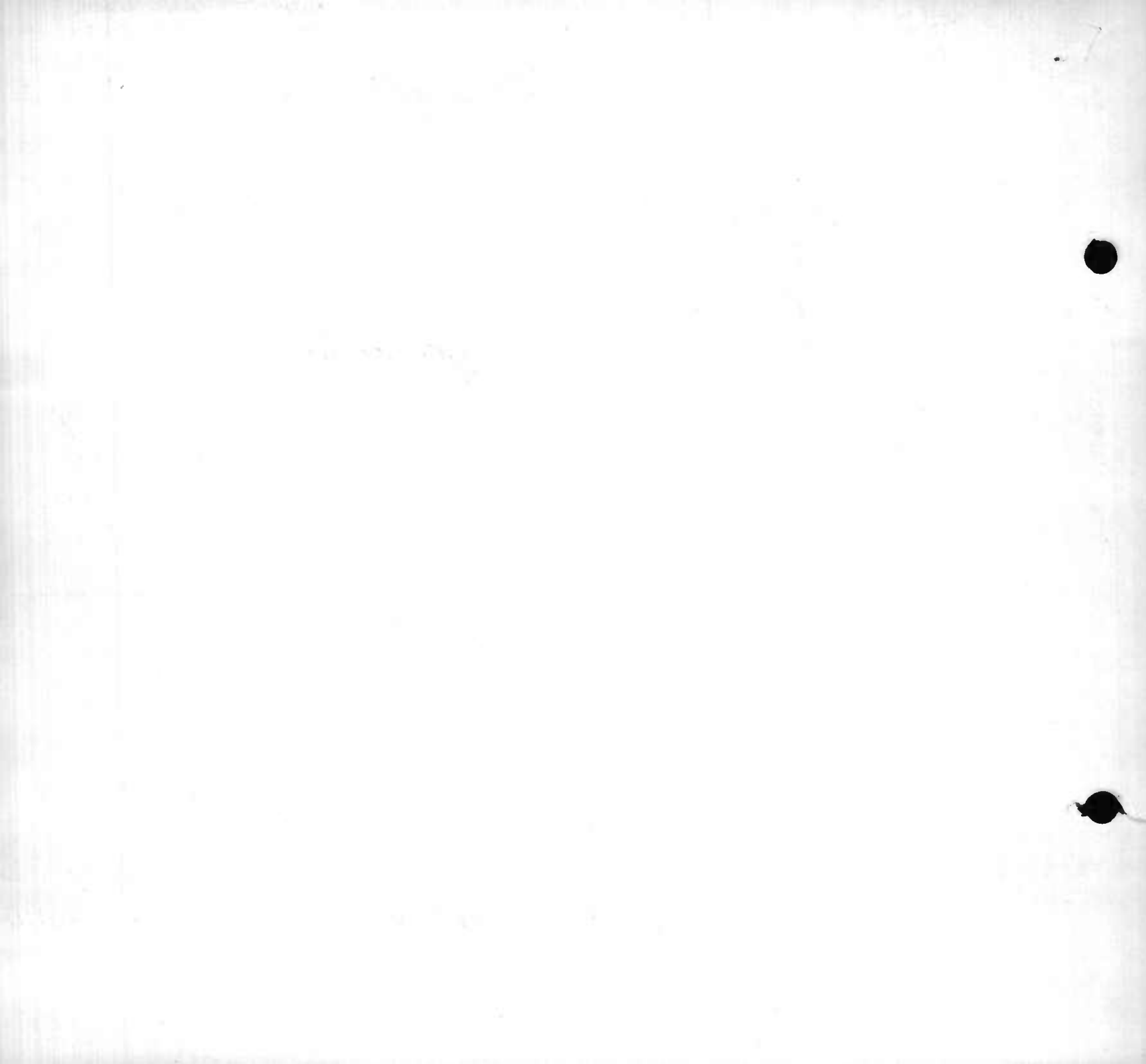
1-22-57

THE
CIRGLE
OF
THE
CIRGLE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

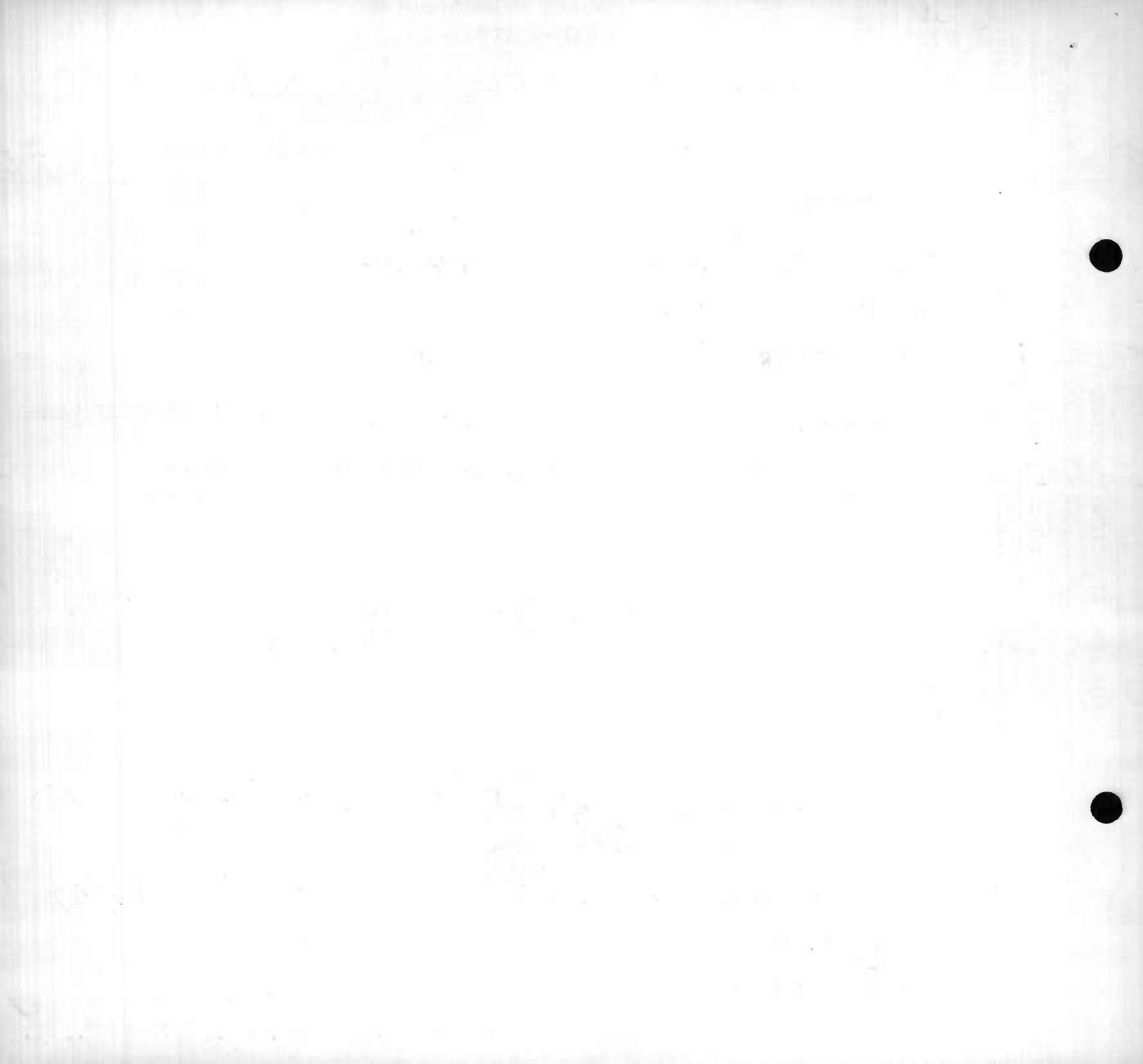
BIRTH NO. 67 5368		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5368	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Fanny Finger</i>		2. DATE AND HOUR OF DEATH <i>Sun May 28 / 67 6⁰⁰ P.-M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 4613 Park Hts Ave Mt. Sinai Nursing Home</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-16</i>			
		D. STREET ADDRESS (If rural, give location) <i>4613 Park Heights Ave</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH	9. AGE (In years, lost birthday) <i>76</i>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Samuel Finger</i>			14. MOTHER'S MAIDEN NAME <i>Charma Yompolski</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT ADDRESS <i>Hebrew Free Burial Society</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i>		CAUSE OF DEATH (A) DUE TO <i>Acute myocardial Infarction</i> (B) DUE TO <i>Hypertensive C.V. Disease</i> (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>3 years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>none</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 19</i> 1964 to <i>May 28</i> 1967, that (I) (we) last saw the deceased alive on <i>May 28</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Manuel Levin</i>				23B. DATE SIGNED <i>5/29/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN</i>				23D. ADDRESS <i>4818 REISTERSTOWN RD BALTO MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 31/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Ches Shalom</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Fink</i>		25C. FUNERAL DIRECTOR <i>St. John's & Son - 600 Kent. Rd.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

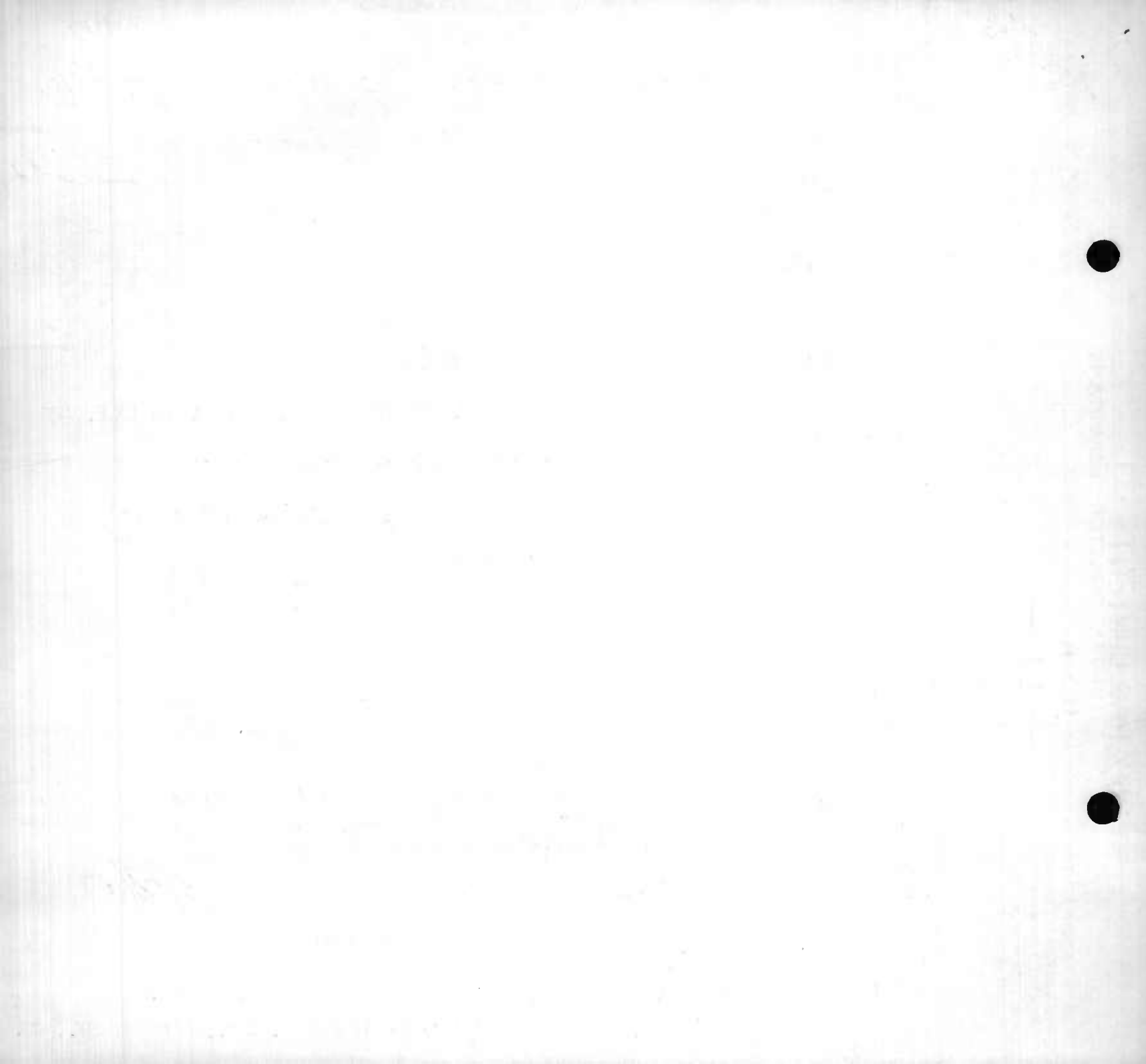
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5369	
BIRTH NO. 67 5369		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 5/28/67 9:00 P.M.	
1. NAME OF DECEASED (Type or Print) FRIEDMAN, ETHEL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL		D. STREET ADDRESS (If rural, give location) 6018 WOODCREST AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH MAY 30, 1894
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 72
13. FATHER'S NAME BERNARD KRETCHMAR		11. BIRTHPLACE (State or foreign country) RUSSIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO. UNKNOWN		14. MOTHER'S MAIDEN NAME GUSSIE ?	
17. INFORMANT MR. MORRIS FRIEDMAN, 6018 WOODCREST AVENUE		ADDRESS	
18. 422.14260 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HYPOTHYROIDISM DIABETES MELLITUS		(B) ?	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/26 1967 to 5/28 1967 , that (I) (we) last saw the deceased alive on 5/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE James Sobel		23B. DATE SIGNED 5/28/67	
23C. PHYSICIAN'S NAME (Type) DR. JAMES SOBEL		23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/30/67	
24C. NAME of CEMETERY or CREMATORY AGUDAS ACHIM ANSHE SEARD		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Farber	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5370					CERTIFICATE OF DEATH			Registered No. 67 5370	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ANNA STROMWATER					2. DATE AND HOUR OF DEATH 5/28/67 4 55/A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-20 D. STREET ADDRESS (If rural, give location) 3801 CLARKS LANE, APT B				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 12/6/1896	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME CHARLES TEITELBAUM					14. MOTHER'S MAIDEN NAME ALICE ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MR. SOL STROMWATER, 3801 CLARKS LANE, APT B				
18. I. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INSUFF. DUE TO MYOCARDIAL INFARCTION(S) DUE TO ASCUB.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that X (this hospital) attended the deceased from 4/13 19 67 to 5/28 19 67 , that X (we) last saw the deceased alive on 5/28 19 67 and that in X (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (We) (did) (did not) view the body after death.									
23A. SIGNATURE Raymond L. Copier					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/28/67		
23C. PHYSICIAN'S NAME (Type) DR. RAYMOND L. COPIER					23D. ADDRESS SINAI HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5/29/67		24C. NAME OF CEMETERY or CREMATORY CHIZUK AMINO, (ARLINGTON)		24D. LOCATION BALTIMORE, MARYLAND		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			25B. NAME OF REGISTRAR Bliss E. Farley		25C. FUNERAL DIRECTOR SOL DEVINSON & BROS. INC., 6010 REIST., RD.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5371		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5371	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Rose Bograd</i>		2. DATE AND HOUR OF DEATH <i>May 28, 1967 8A M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-17</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>904613 Park Heights One Mt. Sinai Nursing Home</i>		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>2855 W. Garrison One</i>	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>73</i>	9. AGE (In years lost birthday) <i>73</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>Araron Silchonek</i>		14. MOTHER'S MAIDEN NAME <i>Mamie?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT ADDRESS <i>Mrs Esther Sapperstein - 3314 Essex Rd.</i>	
18. <i>420.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>none</i>		CAUSE OF DEATH <i>Intermittent Heart Disease</i> DUE TO <i>none</i> (B) DUE TO <i>none</i> (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 29 1964</i> to <i>May 28 1967</i> , that (I) (we) last saw the deceased alive on <i>May 28 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Manuel Levin</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/29/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN</i>		23D. ADDRESS <i>4818 Redoubt Rd Baltimore Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>May 29/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Workmen Circle</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1967</i>			
25B. NAME OF REGISTRAR <i>Robert S. Taylor</i>		25C. FUNERAL DIRECTOR <i>Inc Sol Legum</i>			
25D. ADDRESS <i>6010 Rust Road</i>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

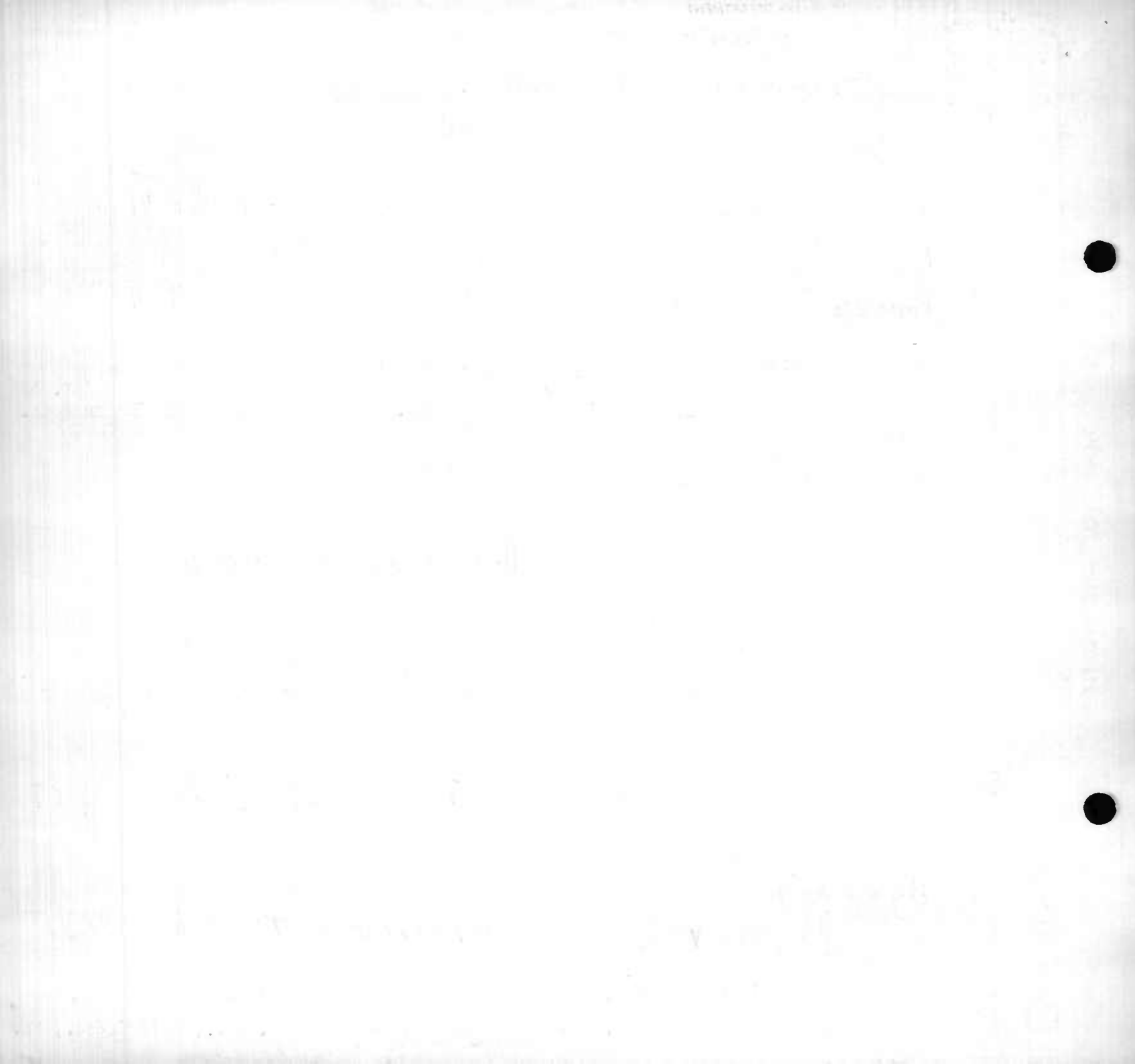
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5372	
BIRTH NO. 67 5372		HENDEL		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ANNIE XXXX GOLDSCHER		2. DATE AND HOUR OF DEATH May 28, 1967 4:10 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-19 D. STREET ADDRESS (If rural, give location) 3919 Emmart Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 4-18-1885	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Solomon Austerlitz			14. MOTHER'S MAIDEN NAME Frieda Schwartz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Mrs. Ray Hurwitz	
				ADDRESS 3919 Emmart Avenue 21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 451 XI		CAUSE OF DEATH (A) Direct myocardial infarction DUE TO Hypertensive + ASCVD (B) 5-10 years DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 1962 to 5-27-1967 that (I) (we) last saw the deceased alive on 5-27-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julius Waghlestein				23B. DATE SIGNED 5-28-67	
23C. PHYSICIAN'S NAME (Type) Julius Waghlestein				23D. ADDRESS 1010 St. Paul Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/28/1967		24C. NAME OF CEMETERY or CREMATORY Adas Israel Anshe Sfard	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			
25B. NAME OF REGISTRAR R. E. E. E. E. E.		25C. FUNERAL DIRECTOR S. L. E. E. E. E. E.			
ADDRESS 6010 Reisterstown Road					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

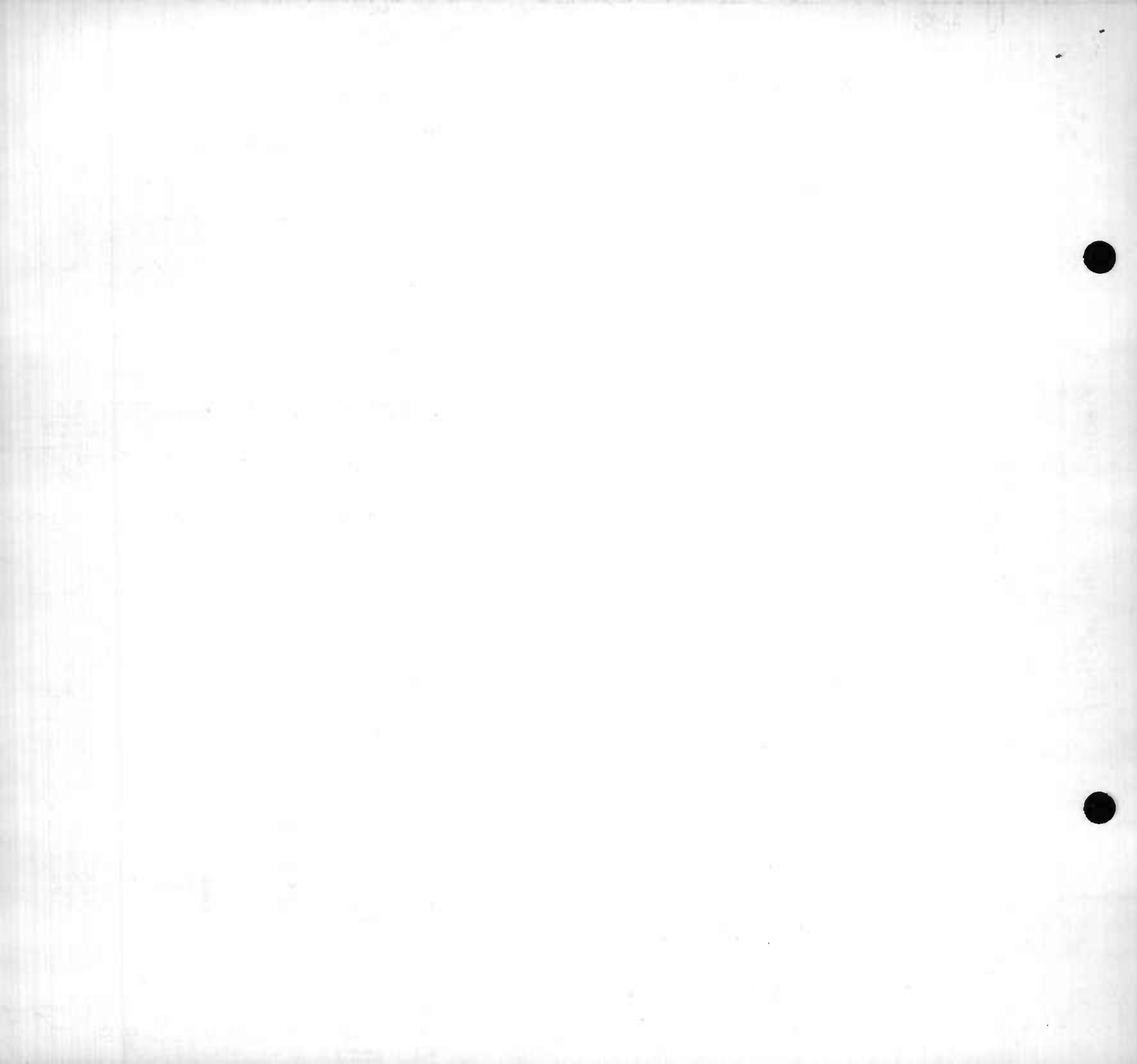
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>67 5373</u>	
BIRTH NO. <u>67 5373</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>SINSHEIMER BERTHA R.</u>		2. DATE AND HOUR OF DEATH <u>5-28-67</u> <u>4 PM</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>NORTH CHARLES GENERAL HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>13-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>TEMPLE GARDEN Apts. Balt. Md. Apt. 603</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>9-16-90</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon Robinson</u>			14. MOTHER'S MAIDEN NAME <u>Father Levy</u>			ADDRESS <u>Apt. 603</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-22-5395</u>		17. INFORMANT <u>Mrs. Belle Buckman, Temple Garden Apts.</u>			
18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO <u>PNEUMONIA</u> (B) DUE TO <u>ARTERIOSCLEROSIS HEART</u> (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-28-67</u> to <u>5-28-67</u> that (I) (we) last saw the deceased alive on <u>5-28-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Alfred C. Gentry</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-28-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. SILVER</u>				23D. ADDRESS <u>STRATHMORE TOWER APTS 21215</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/31/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Sol. Leginson & Bros. Inc., 6010 Reist., Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5374		CERTIFICATE OF DEATH		67 5374	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <i>Esther Paris</i>		
2. DATE AND HOUR OF DEATH <i>6-1-67 1:30 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital 37</i>			A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i>			D. STREET ADDRESS (If rural, give location) <i>4119 Crestheights Rd.</i>		
5. SEX <i>F</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>10-18-08</i>	9. AGE (in years last birthday) <i>58</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALES LADY</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>RETAIL</i>		11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>HARRIS FREEDMAN</i>		14. MOTHER'S MAIDEN NAME <i>MARY FERMAN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214-14-9850</i>		17. INFORMANT <i>MR. DAVID PARIS, 4119 CRESTHEIGHTS ROAD</i>	
18. <i>199.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>Generalized carcinomatosis at least one year</i> ANTECEDENT CAUSES <i>Carcinoma, abdominal more than one year</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>April 1966</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory laparotomy</i>		20A. AUTOPSY? (Yes or No) <i>No.</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that the (this hospital) attended the deceased from <i>5-31-67</i> to <i>6-1-67</i> , that the (we) last saw the deceased alive on <i>5-31-67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.			
23A. SIGNATURE <i>Yinglang Lin</i>		M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>June 1, 1967</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ying-lang Lin</i>		M.D. <i>Mercy Hospital</i>		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/2/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>OHEL YAKOV</i>	
24D. LOCATION (City, town, or county) <i>BALTIMORE, MARYLAND</i>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1967</i>		25B. NAME OF REGISTRAR <i>Edna E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Edna E. Johnson Bros. F.A.</i>	
25D. ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5375				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5375	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Lena Rudman				2. DATE AND HOUR OF DEATH June 1, 1967 10³⁰ a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Levin Dale, Hebrew Home and Infirmary				A. STATE MARYLAND B. COUNTY BALTIMORE			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 2529 KEYWORTH AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 3-17-1884	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Hofsovit				14. MOTHER'S MAIDEN NAME Gittel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT MRS. BETTY MOFSOVITZ, 2543 Steele Road, Apt. B	
18. 493 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pneumonia				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCD + CHF				(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8-1-1966 to 6-1-1967 , that (I) (we) lost saw the deceased alive on 6-1-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.							
23A. SIGNATURE Ruth Willner				M.D. <input type="checkbox"/> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-1-67	
23C. PHYSICIAN'S NAME (Type) Ruth Willner				23D. ADDRESS Levin Dale, Hebrew Home and Infirmary			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/2/67		24C. NAME of CEMETERY or CREMATORY Workmen Circle		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR Sol Levinson & Bros, Inc., 6010 Reist., Rd.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5376
BIRTH NO. 67 5376		CERTIFICATE OF DEATH								
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MOSES FEINMAN				2. DATE AND HOUR OF DEATH 6-1-67 6:50 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA C. CITY OR TOWN (If outside city limits, write RURAL and give township) LYNCHBURG D. STREET ADDRESS (If rural, give location) PRINCETON CIRCLE WEST APT 42				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-10-04	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY GENERAL MERCHANDISE		11. BIRTHPLACE (State or foreign country) Lynchburg - Va		12. CITIZEN OF WHAT COUNTRY? U.S.A				
13. FATHER'S NAME ABRAHAM FEINMAN			14. MOTHER'S MAIDEN NAME ELIZABETH FISHER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Hospital Records		ADDRESS			
18. 201 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) HODGKINS DISEASE DUE TO (B) involvement of brain, liver, lungs DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (this hospital) attended the deceased from 4-28 19 67 to 6-1 19 67 , that (we) last saw the deceased alive on 6-1 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.										
23A. SIGNATURE Daniel C. Hadlock M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-1-67		
23C. PHYSICIAN'S NAME (Type) DANIEL C. HADLOCK				23D. ADDRESS 507 REED HALL, 1620 McELDERRY ST.						
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 6-1-67		24C. NAME OF CEMETERY or CREMATORY Agudas Shalom		24D. LOCATION (City, town, or county) (State) Lynchburg - Va.				
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR 8810		ADDRESS 205-9 INC-REISTERSTOWN RD				

9/10

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

10-1-0

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5377					CERTIFICATE OF DEATH				
Registered No. 67 5377									
1. NAME OF DECEASED (Type or Print) CYRIL VICTOR WATKINS					2. DATE AND HOUR OF DEATH JUNE 3RD 1967 2:30 P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL					A. STATE ENGLAND B. COUNTY DEVON				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) LIVERTON (NEATON ABBOT)				
					D. STREET ADDRESS (If rural, give location) 5 SUMNER HILL RD				
5. SEX M					6. RACE W				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED					8. DATE OF BIRTH 11-8-1894				
9. AGE (In years last birthday) 72					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VETERINARY				
11. BIRTHPLACE (State or foreign country) ENGLAND					12. CITIZEN OF WHAT COUNTRY? ENGLAND				
13. FATHER'S NAME WILLIAM POWELL WATKINS					14. MOTHER'S MAIDEN NAME CATHERINE ANN BRYAN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service) NO					16. SOCIAL SECURITY NO. —				
17. INFORMANT WILLIAM R WATKINS					ADDRESS 3120 WEAVER AVE. (14)				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CEREBRO VASCULAR ACCIDENT					INTERVAL BETWEEN ONSET AND DEATH 6 HRS.				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE									
21. DATE OF OPERATION —					22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
23. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —					24. WHERE DID INJURY OCCUR? —				
25. TIME OF INJURY (Month) (Day) (Year) (Hour) —					26. HOW DID INJURY OCCUR? —				
27. I certify that (I) (this hospital) attended the deceased from JUNE 3RD 1967 to JUNE 3 1967 , that (I) (we) last saw the deceased alive on JUNE 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
28. SIGNATURE R. S. Patten					29. DATE SIGNED JUNE 3RD 1967				
30. PHYSICIAN'S NAME (Type) —					31. ADDRESS —				
32. BURIAL CREMATION, REMOVAL (Specify) Cremation					33. DATE 6/5/67				
34. NAME OF CEMETERY or CREMATORY Greenmount					35. LOCATION (City, town, or county) (State) Baltimore, Md.				
36. DATE REC'D BY HEALTH DEPT. JUN 5 1967					37. NAME OF REGISTRAR R. S. Patten				
38. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Balt. Md					39. ADDRESS 21202				

11-2-1034 25

William Foster Whitin

55

Robert B. Anderson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5378		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5378	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) BABY LIVELY			2. DATE AND HOUR OF DEATH 6-2-67 6:00 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE UNION MEMORIAL HOSP 44			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 13-08 D. STREET ADDRESS (If rural, give location) 4128 WILSON PLACE		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6-1-67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min: 10 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ROY LEE			14. MOTHER'S MAIDEN NAME CAROL PICKERAL		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MOTHER	
18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PREMATURE INFANT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. HEMORRHAGE OF SCALP			INTERVAL BETWEEN ONSET AND DEATH A.B. JENNY		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6-1-67 to 6-2-67 , that (I) (was) last saw the deceased alive on 6-2-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Parker			23B. DATE SIGNED 6-2-67		
23C. PHYSICIAN'S NAME (Type) JOSEPH PARKER			23D. ADDRESS THE UNION MEMORIAL HOSP		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Wm. Cook-Brooks, Inc.		25C. FUNERAL DIRECTOR ADDRESS 1217 St. Paul St.	

THE LIONEL LIONEL LIONEL

6-1-67

Now
Ray Lee
No
Now
Now
Now

John
Lionel

6-1-67
6-1-67
6-1-67

X
6-1-67
The Lionel

1
m-22067 5379
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5379

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

MUSACCHIO

2. DATE AND HOUR PRONOUNCED DEAD

June 2, 1967

7:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

39 PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1832 Bolton Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Feb. 2, 1909

9. AGE (in years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Dominic Musacchio

14. MOTHER'S MAIDEN NAME

Raffel Gaspari

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Don Musacchio 5001 Barton Av. Balto. Md. 21206

18. E 916.0 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple Injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1832 Bolton Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6/2/67 5:15 P. M.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Jumped from the
second floor of burning house

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

6/3/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/6/67

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 5 1967

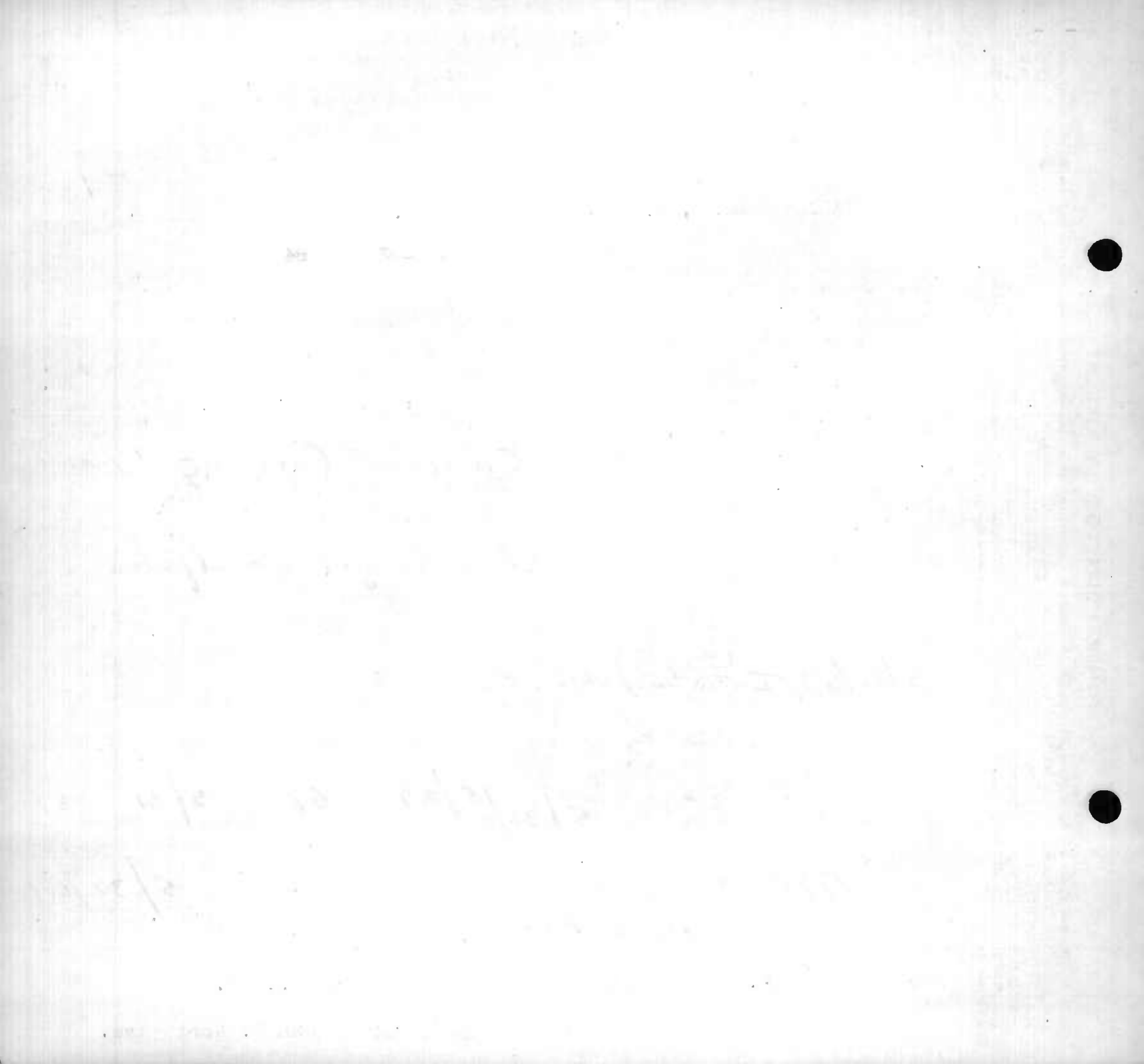
Wm. Cook-Brooks, Inc. 1217 St. Paul St.

FOUR

FUNERAL DIRECTOR: IMPORTANT

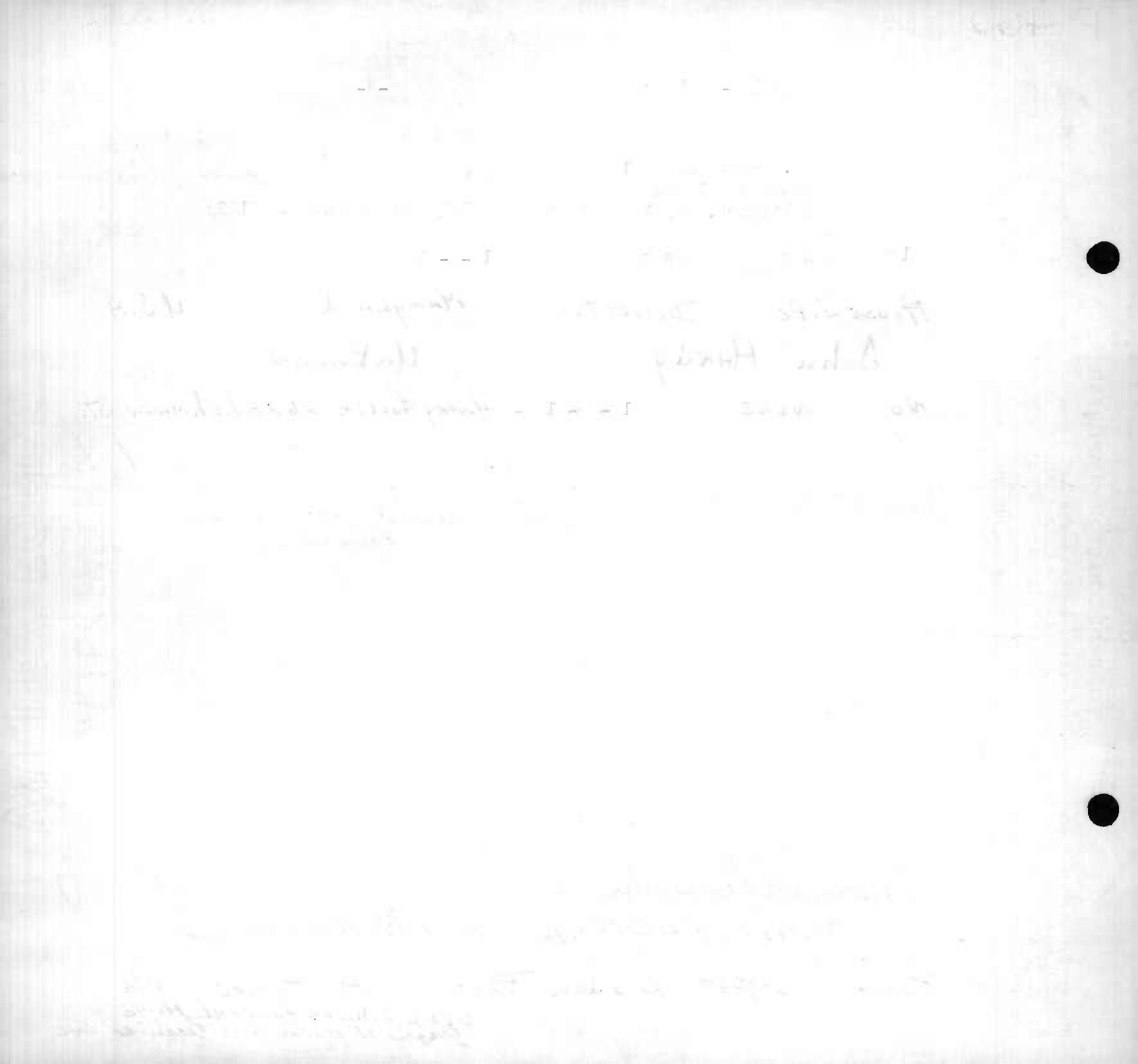
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 636 67 5380		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5380	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Pearl Toney CARTER		5/31/67 12 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE 21224, MARYLAND		A. STATE MARYLAND			
		B. COUNTY			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		113 W. 22nd STREET #21218			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 3-17-03	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				VIRGINIA	
13. FATHER'S NAME ALLEN CARTER		14. MOTHER'S MAIDEN NAME NANNIE WHITHEAD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MD. RECORDS: BCH 4940 EASTERN AVENUE BALTO 21224,	
18. 153.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cancer of Caecum / Intestinal Obstruction (B) DUE TO INANITION (C) Chronic Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH?	
19A. DATE OF OPERATION 5/30/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/29 1967 to 5/31 1967, that (I) (we) last saw the deceased alive on 5/31/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. A. Alonso M.D.		23B. DATE SIGNED 5/31/67			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67		24C. NAME OF CEMETERY or CREMATORY Balto National Cemetery Balto., Md.	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR J. B. E. Taylor		25C. FUNERAL DIRECTOR Jm J March 928 E. North Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5381				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5381	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Minnie - Fuller				2. DATE AND HOUR OF DEATH 6-4-67 8 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF (If not in hospital or institution, give street INSTITUTION address or location) 40 St. Agnes Hospital Caton & Wilkens Avenue Baltimore, Maryland 21223				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2623 Lehman Street #21223			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10-5-83	9. AGE (In years last birthday) 83	If Under 1 Yr. If Under 24 Hrs. Months: Days Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hardy				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 213-05-3128-D		17. INFORMANT Harry Fuller ADDRESS 2623 Lehman St			
18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion INTERMITTENT CARDIOVASC DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1958 to 6-4-1967 that (I) (we) last saw the deceased alive on 6-4-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Justinas Kudirka M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-4-67	
23C. PHYSICIAN'S NAME (Type) Justinas KUDIRKA M.D.				23D. ADDRESS 2151 Wilkens Ave			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-7-67		24C. NAME OF CEMETERY or CREMATORY LONDON PARK		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR GEORGE L. SCHWAB FUNERAL HOME Gregory D. Miller 2101 Rudolph Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5382		CERTIFICATE OF DEATH		Registered No. 67 5382		
1. NAME OF DECEASED (Type or Print) Charles F. Gouldman				2. DATE AND HOUR OF DEATH 6/2/67 8:50 P.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-48 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 6224 NORTHWOOD DRIVE 21212						
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 6-2-53	9. AGE (In years last birthday) 14	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student			10B. KIND OF BUSINESS OR INDUSTRY student		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME PHILIP GOULDMAN				14. MOTHER'S MAIDEN NAME EILEEN DUNN						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. none		17. INFORMANT Philip H. Gouldmann				ADDRESS 6224 Northwood Dr.	
18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) lymphosarcoma ? Auto infection ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 months				
				(A) DUE TO						
		(B) DUE TO								
		(C) DUE TO								
MEDICAL CERTIFICATION										
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 6/2 19 67 to 6/2 19 67 that (I) (we) last saw the deceased alive on 6/2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE David S Fedson M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/2/67				
23C. PHYSICIAN'S NAME (Type) DAVID S FEDSON M.D.				23D. ADDRESS The Johns Hopkins Hospital						
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 6/6/67		24C. NAME of CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. Balto., Md. 21212				

8-29

6/5/67

Charles (continuation)

Mythrascon
Antefeb

yes

6/5

6/5

6/5

6/5/67

The Johns Hopkins Hospital

DAVID S. FETTER
James Z. Fetter

BIRTH NO. **67 5383** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 5383**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE A. SHAW

2. DATE AND HOUR PRONOUNCED DEAD

5-30-67

10:50 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33 JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1212 Division Street 21217

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12-6-1890

9. AGE (in years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Allen Boyd

14. MOTHER'S MAIDEN NAME

Candy Mayle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Thomas Shaw 2524 Francis St.

18.

332 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral infarct
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Hypertensive and arteriosclerotic
cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

5-31-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

6/2/67

23C. NAME of CEMETERY or CREMATORY

St. Stephens

23D. LOCATION

Blackbridge

(City, town, or county)

(State)

V.A.

24A. DATE REC'D BY HEALTH DEPT.

JUN 5 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Wright

ADDRESS

1727 N. Mount St.

100-100-100
100-100-100
100-100-100
100-100-100

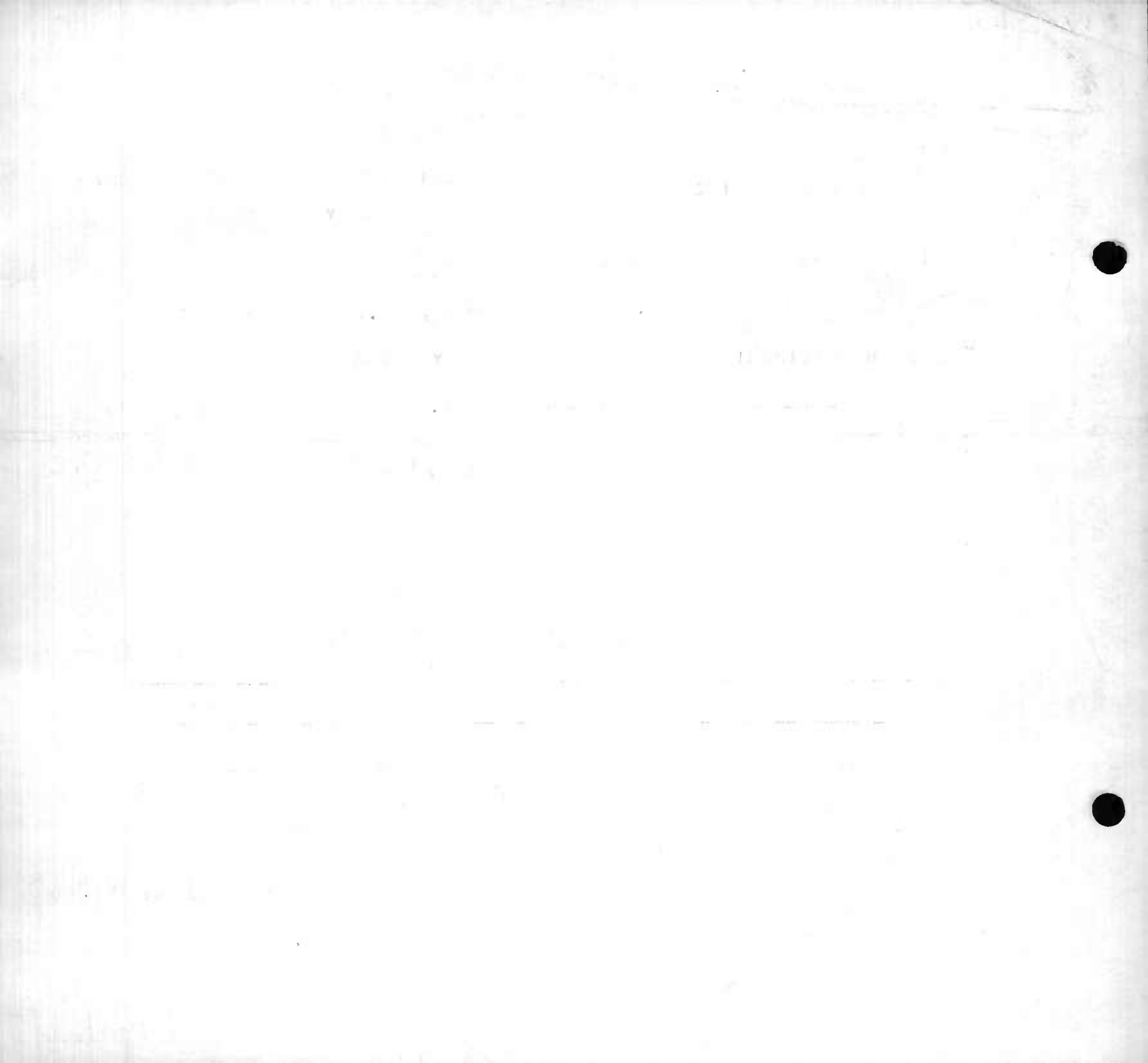
100-100-100
100-100-100
100-100-100

100-100-100
100-100-100
100-100-100

100-100-100
100-100-100
100-100-100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

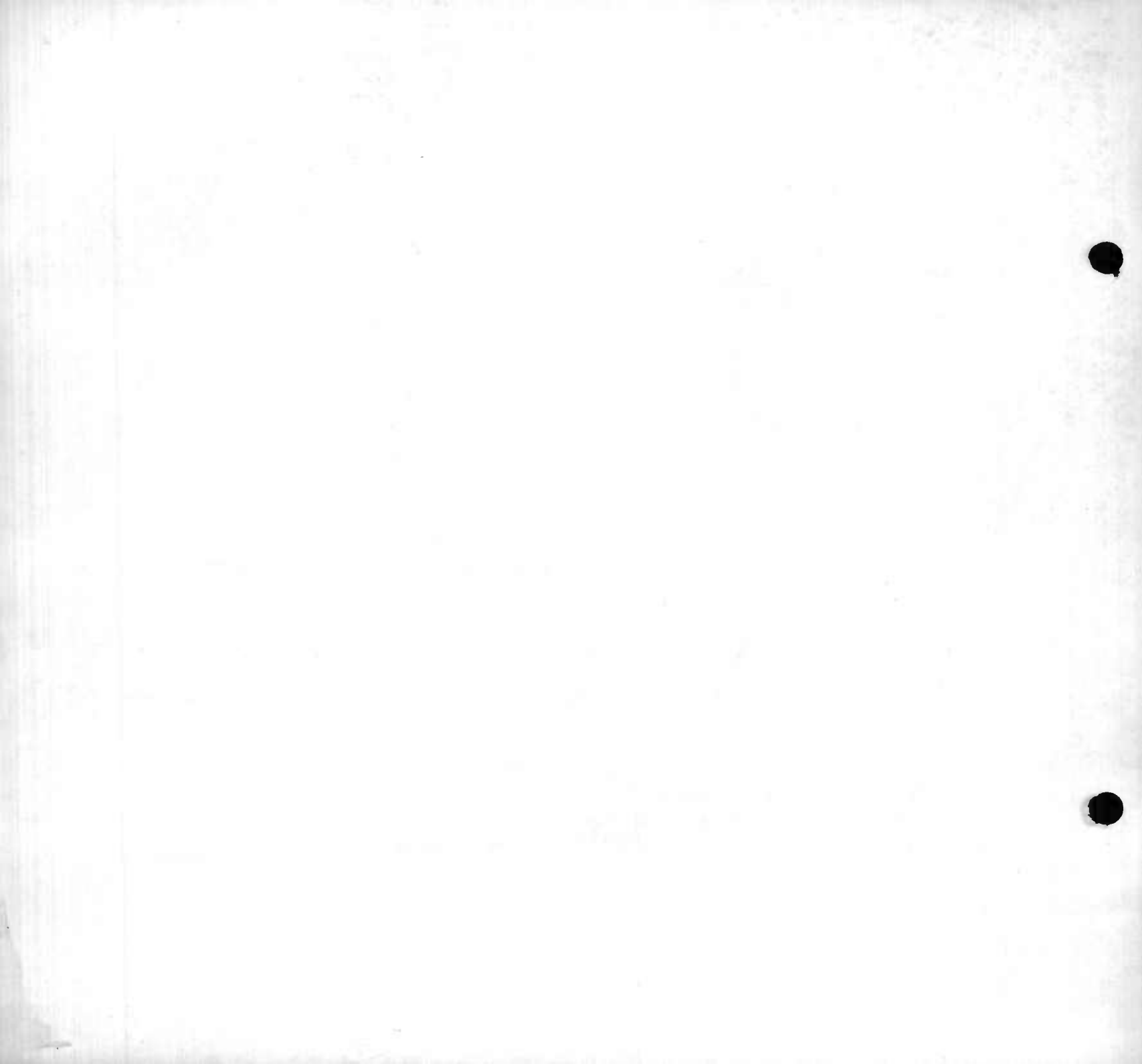
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5384	
BIRTH NO. 67 5384		CERTIFICATE OF DEATH			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) Ann M. Wasilewski (or) Wasielewska			2. DATE AND HOUR OF DEATH June 4, 1967 9:30 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS			A. STATE MARYLAND B. COUNTY		
			C. CITY OR TOWN (If outside city limits, with RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3416 JUNEWAY		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/11/06	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blue Print Clerk		10B. KIND OF BUSINESS OR INDUSTRY Glenn L. Martin	11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOSEPH SMOLINSKI			14. MOTHER'S MAIDEN NAME MARY JANKA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-20-5946	17. INFORMANT ADDRESS Adam J. Wasilewski 3416 Juneway 21213		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) 416X I			CAUSE OF DEATH (A) Rheumatic Heart Disease DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 53 yrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Congestive Heart Failure		3 yrs
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner)		21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED <input checked="" type="checkbox"/> While At Work <input type="checkbox"/> While At Home		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 7 1967 to June 4 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 4 1967 and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> did (did not) view the body after death.					
23A. SIGNATURE Joseph Silva			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 4, 1967
23C. PHYSICIAN'S NAME (Type) Joseph Silva			23D. ADDRESS John Hopkins Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE JUNE 7 67	24C. NAME of CEMETERY or CREMATORY HOLY CROSS CEM	24D. LOCATION (City, town, or county) (State) GERMAN HILL Rd MD		
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967	25B. NAME OF REGISTRAR John E. Talbot		25C. FUNERAL DIRECTOR ADDRESS Supple Bros Inc 1800 E Lombard St		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

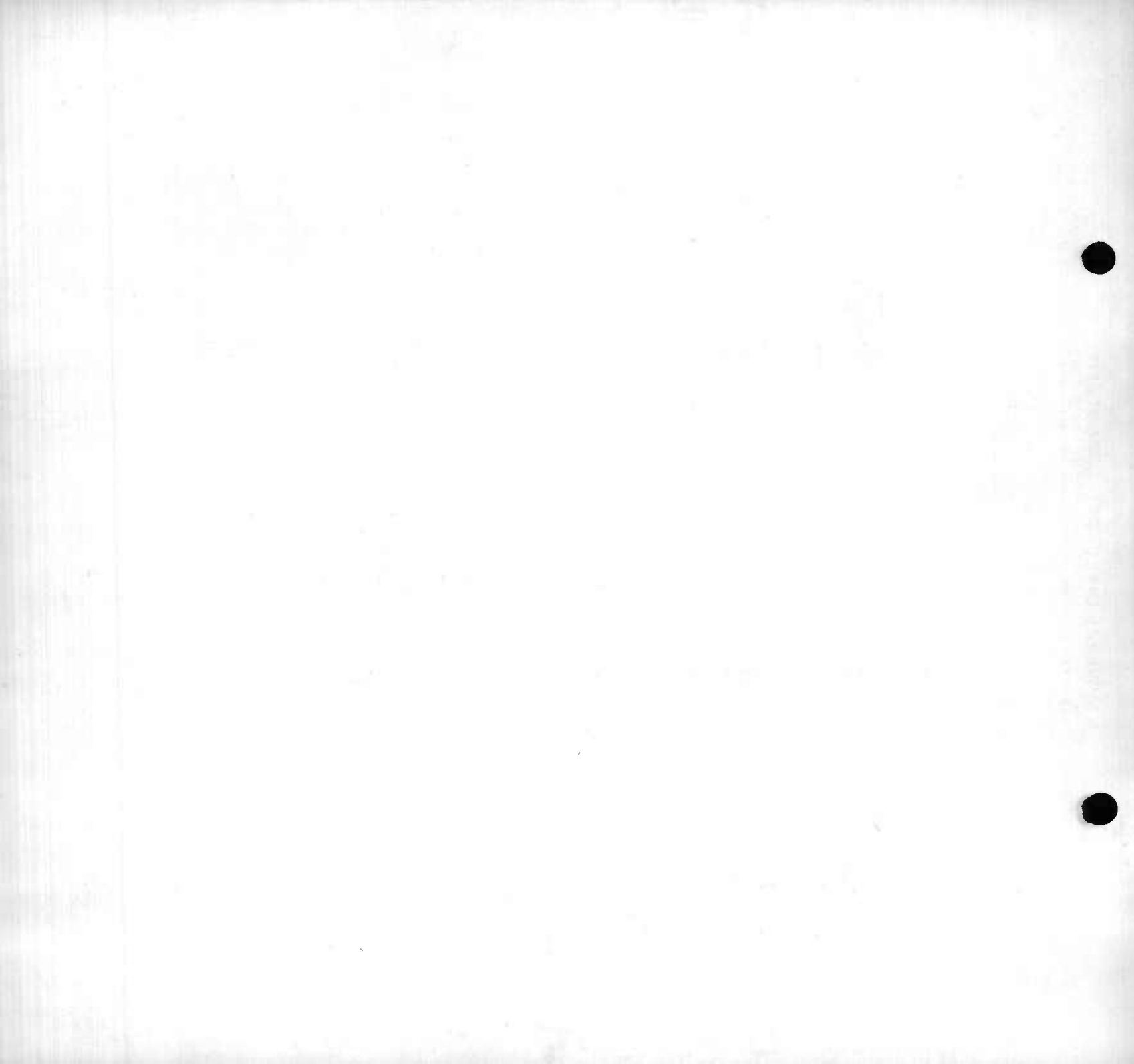
BIRTH NO. 67 5385				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5385	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIE FRAZIER				2. DATE AND HOUR OF DEATH 6/1/67 9:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE Hosp.				A. STATE MARYLAND B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 643 N. CALHOUN ST.			
5. SEX W F		6. RACE N N		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 8/1/07	
						9. AGE (In years last birthday) 60	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Glover				14. MOTHER'S MAIDEN NAME Cora Cook			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-22-7525		17. INFORMANT ADDRESS Ernest Frazier (Nephew) Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 452X I Pneumonia & (R) Intussusception Caused artery				CAUSE OF DEATH Interval between onset and death			
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/25 19 67 to 6/1 19 67 that (I) (we) last saw the deceased alive on 6/1/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Kravitz						23B. DATE SIGNED 6/1/67	
23C. PHYSICIAN'S NAME (Type) DR. KRAVITZ						23D. ADDRESS FRANKLIN SQ. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-5-67		24C. NAME OF CEMETERY or CREMATORY Carver Mem. Park		24D. LOCATION (City, town, or county) (State) Laurel Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR W. D. Dyer		ADDRESS 1701 LAYMAN	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5386	
BIRTH NO. 67 5386		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) JACKSON NETTIE		2. DATE AND HOUR OF DEATH 6/2 / 66 11:20 A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY of MD. Hosp.		A. STATE Md. B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21216			
		D. STREET ADDRESS (If rural, give location) 2511 Riggs Ave			
5. SEX F	6. RACE N	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5/27/32	9. AGE (In years last birthday) 35	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H/W		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph NELSON			14. MOTHER'S MAIDEN NAME NETTIE WEST		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-34-4268		17. INFORMANT ADDRESS Mr. Albert Jackson 524 N. Mount St.	
18. 4 10 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO post-operative pulmonary embolism (B) DUE TO e infarction and (C) Calcific Mitral stenosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5/31		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Mit. Embolism & Calcific Mitral Stenosis		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/31 19 66 to 6/2 19 67 , that (I) (he) last saw the deceased alive on 6/2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bon Iranzi				23B. DATE SIGNED 6/2/67	
23C. PHYSICIAN'S NAME (Type) B. N. IRANZI				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6-6-67	24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Hall		25C. FUNERAL DIRECTOR ADDRESS 1701 Laurens	



1
E-152

67 5387

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5387

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD EVANS

2. DATE AND HOUR PRONOUNCED DEAD

6-2-67

4:10 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1010 N. CALHOUN STREET - Amb. Crew #4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1010 N. Calhoun Street 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10-27-1926

9. AGE (in years last birthday)

40

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Self-employed

10B. KIND OF BUSINESS OR INDUSTRY

Grocer

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur Evans

14. MOTHER'S MAIDEN NAME

Virgie Evans

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Arthur Evans

1010 N Calhoun

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive and arteriosclerotic

~~heart~~

heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

6-2-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6-6-67

23C. NAME OF CEMETERY OR CREMATORY

Mount Auburn

23D. LOCATION

BaHo.

(City, town, or county)

(State)

Md.

24A. DATE RECEIVED BY HEALTH DEPT.

24B. NAME OF REGISTRAR

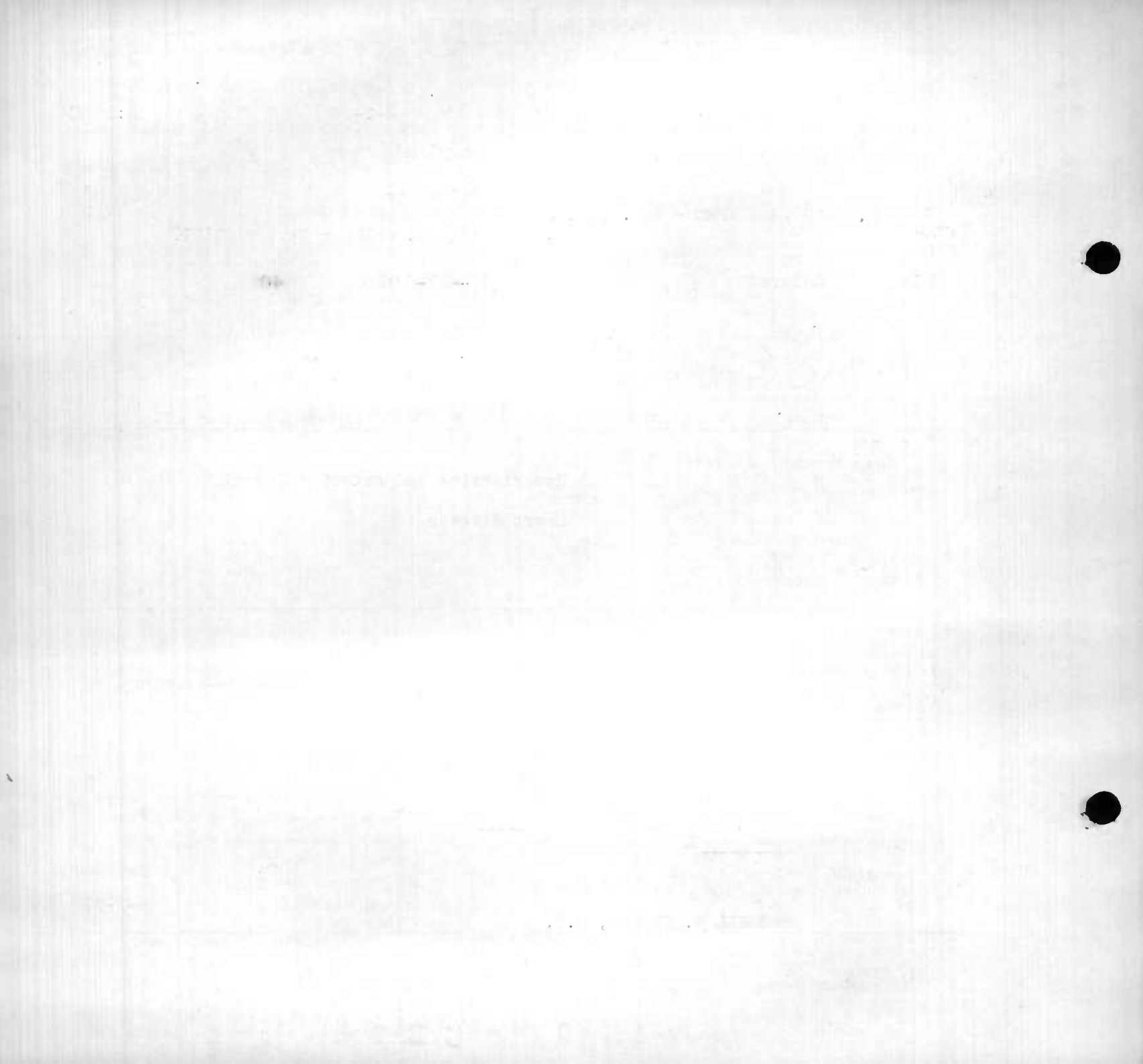
24C. FUNERAL DIRECTOR

ADDRESS

JUN 5 1967

Mortyng & Dyett F.H.

1701 Laurens St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5388	
BIRTH NO. 67 5388		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH June 3, 1967 9:00 P. M.	
1. NAME OF DECEASED (Type or Print) ELSIE Erise Taylor		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6/23/67 6-27-67 Elsinore 2611 Elsinore Ave		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2611 Elsinore Ave	
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH Dec 29, 1888
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 78
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Waddy-- Octavius Waddy		14. MOTHER'S MAIDEN NAME Emma Ball Octavius-Waddy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Aurelia Taylor 2611 Elsinore Ave
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteroseptotic Heart-disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Anteroseptosis		CAUSE OF DEATH (A) Anteroseptotic Heart-disease DUE TO (B) Generalized Anteroseptosis DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2/18, March 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bangrene graft foot	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 15 1964 to June 3 1967 , that (I) (we) last saw the deceased alive on June 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E. Walter Shervington		23B. DATE SIGNED 6/4/67	
23C. PHYSICIAN'S NAME (Type) E. Walter Shervington		23D. ADDRESS 2301 Harlem Ave Balts Md 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/6/67	
24C. NAME OF CEMETERY or CREMATORY Sharon		24D. LOCATION (City, town, or county) (State) Lancaster Co. Va.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Talman	
25C. FUNERAL DIRECTOR Geo. G. Kelson		25D. ADDRESS 1348 N. Calhoun St	

6/23/67 - Correction form from Fundral Director.

APC

V.S. 153

6-27-67

M.H.

1
L-120

BIRTH NO. 67 5389		BALTIMORE CITY HEALTH DEPARTMENT		67 5389	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
ELBERT LOVEJOY			5-31-67 11:50 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2503 Madison Avenue Apt. 7		
2503 MADISON AVENUE - Amb. Crew #1			13-01		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
Male	Colored	Married	7-15-05	61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Ala.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Lovejoy			Emma Cook		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Wilhelmina Lovejoy 2503 Madison Ave.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
(A) Arteriosclerotic cardiovascular disease					
DUE TO					
(B) DUE TO					
(C) DUE TO					
ii OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY	
Burial		6-5-67		Mt. Auburn Cem.	
				23D. LOCATION (City, town, or county) (State)	
				Baltimore, Maryland	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
JUN 5 1967		Robert E. Fisher, M.D.		Kelson Funeral Home 1348 Calhoun St.	

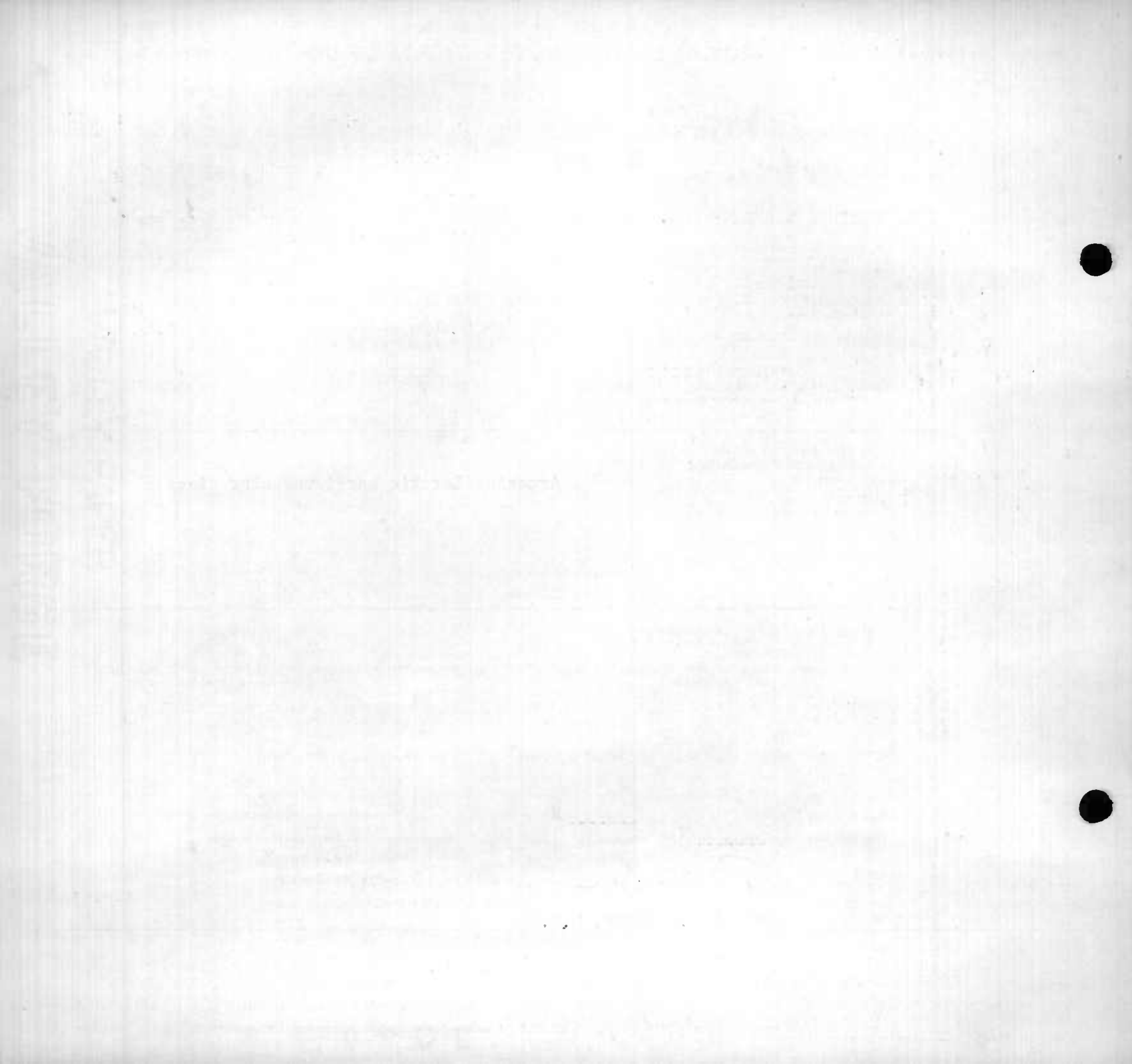
WALLACE P. GIBBS

1964-1965

1
5-362

BALTIMORE CITY HEALTH DEPARTMENT				67 5390
BIRTH NO. 67 5390		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5390		
M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) ROBERT STARKS			2. DATE AND HOUR PRONOUNCED DEAD 6-2-67 8:04 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2227 ETTINGS STREET - Amb. Crew #4			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 14-03 D. STREET ADDRESS (If rural, give location) 2227 Etting Street 21217	
5. SEX Male	6. RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 2-15-78	9. AGE (In years last birthday) 89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N.J.	
13. FATHER'S NAME Abraham Starks			14. MOTHER'S MAIDEN NAME Nancy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218128330	17. INFORMANT ADDRESS Della Starks 2227 Etting Street	
18. 422.1 CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-2-67
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6-2-67	23C. NAME of CEMETERY or CREMATORY Carver Mem. Pk.	23D. LOCATION (City, town, or county) (State) Laurel Maryland
24A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		24B. NAME OF REGISTRAR Dr. J. S. Fisher	24C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St.	

5399



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5391				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5391	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary Hawkins</u>				2. DATE AND HOUR OF DEATH <u>5-31-67</u> <u>6:45 AM</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>1113 N. Longwood St.</u> <u>Mary E. Hawkins</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> D. STREET ADDRESS (If rural, give location) <u>1113 Longwood St.</u>			
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>6-6-19</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Haywood</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Leo Hawkins 1113 Longwood St.</u>			
18. <u>443X 1+260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>HCD</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u> Couple Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Congestive Heart Failure</u> <u>Diabetes mellitus</u>				<u>1 yr.</u> <u>1 yr.</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>May 31</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sat. May 27</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. <u>+ pronounced deceased</u>							
23A. SIGNATURE <u>Lucius W. Leeper</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6-2-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lucius W. Leeper</u>		23D. ADDRESS M.D. <u>1200 Bloomingdale Rd.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-3-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbott</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Kelson Funeral Home-1348 Calhoun St.</u>			

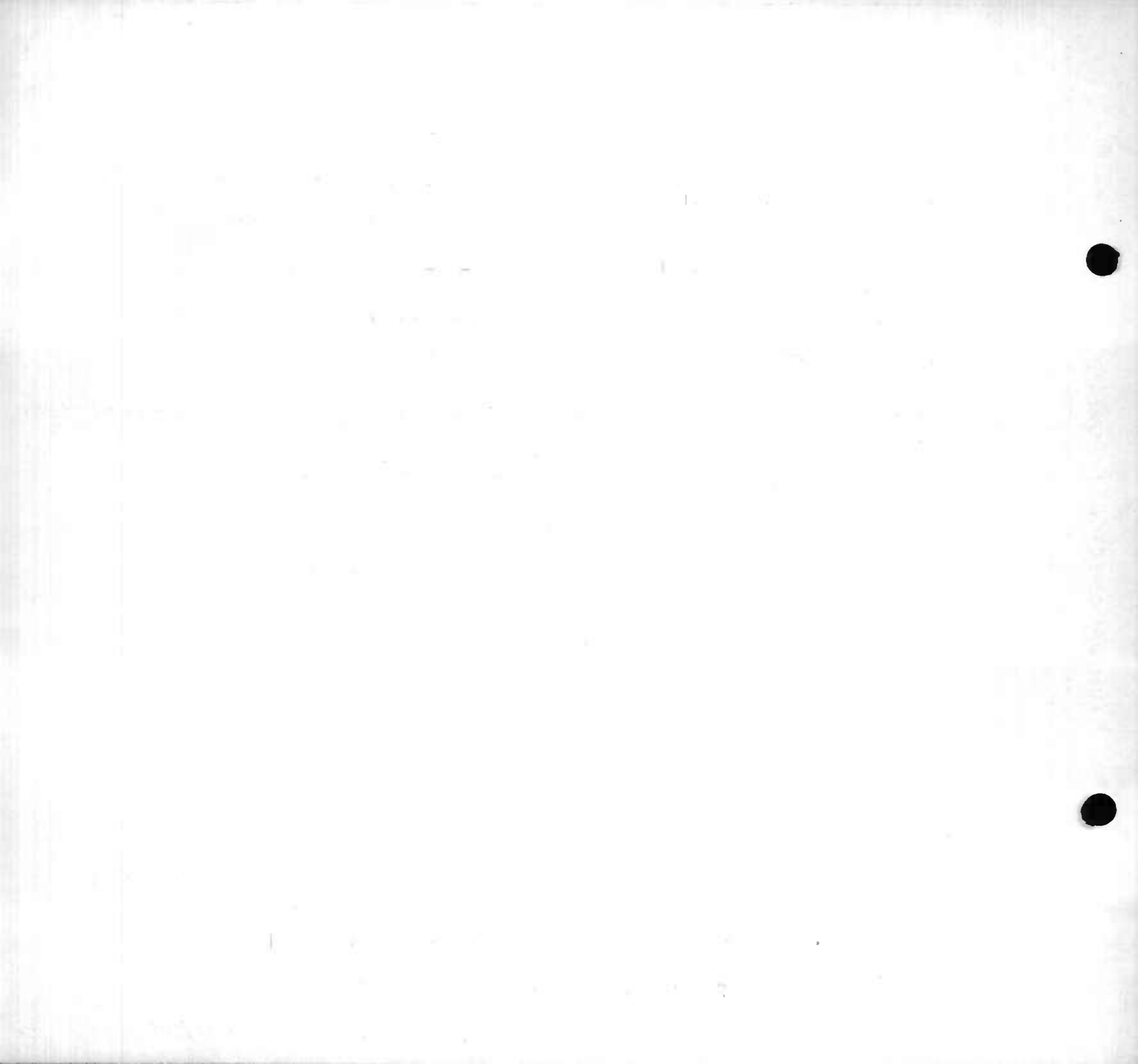
V.S. 153

6-7-67

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5392				Baltimore City Health Department		Registered No. 67 5392	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) ROBERT J. CURLEY				2. DATE AND HOUR OF DEATH 6/1/67 4⁰⁰ AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-03 D. STREET ADDRESS (If rural, give location) 2442 BRENTWOOD AVENUE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-01-97	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS Curley				14. MOTHER'S MAIDEN NAME ELLEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-6927		17. INFORMANT Pauline Curley		ADDRESS 2442 Brentwood Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 3-8-1-01				CAUSE OF DEATH (A) Hepatic Coma, Renal Failure 3 days (B) Portacaval shunt (C) Cirrhosis, Post necrotic		INTERVAL BETWEEN ONSET AND DEATH 7 years	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ? Pneumonia			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 5/29 19 67 to 6/1 19 67 that (2) (we) lost saw the deceased alive on 6/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Rampton				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/1/67	
23C. PHYSICIAN'S NAME (Type) RELPH R. RAMPTON				23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-5-67		24C. NAME OF CEMETERY OR CREMATORY MOUNT CALVARY CEMETERY		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Dr. J. E. Feltman		25C. FUNERAL DIRECTOR Randolph Collick		ADDRESS 2431 E.O. Liver St.	



FUNERAL DIRECTOR: IMPORTANT

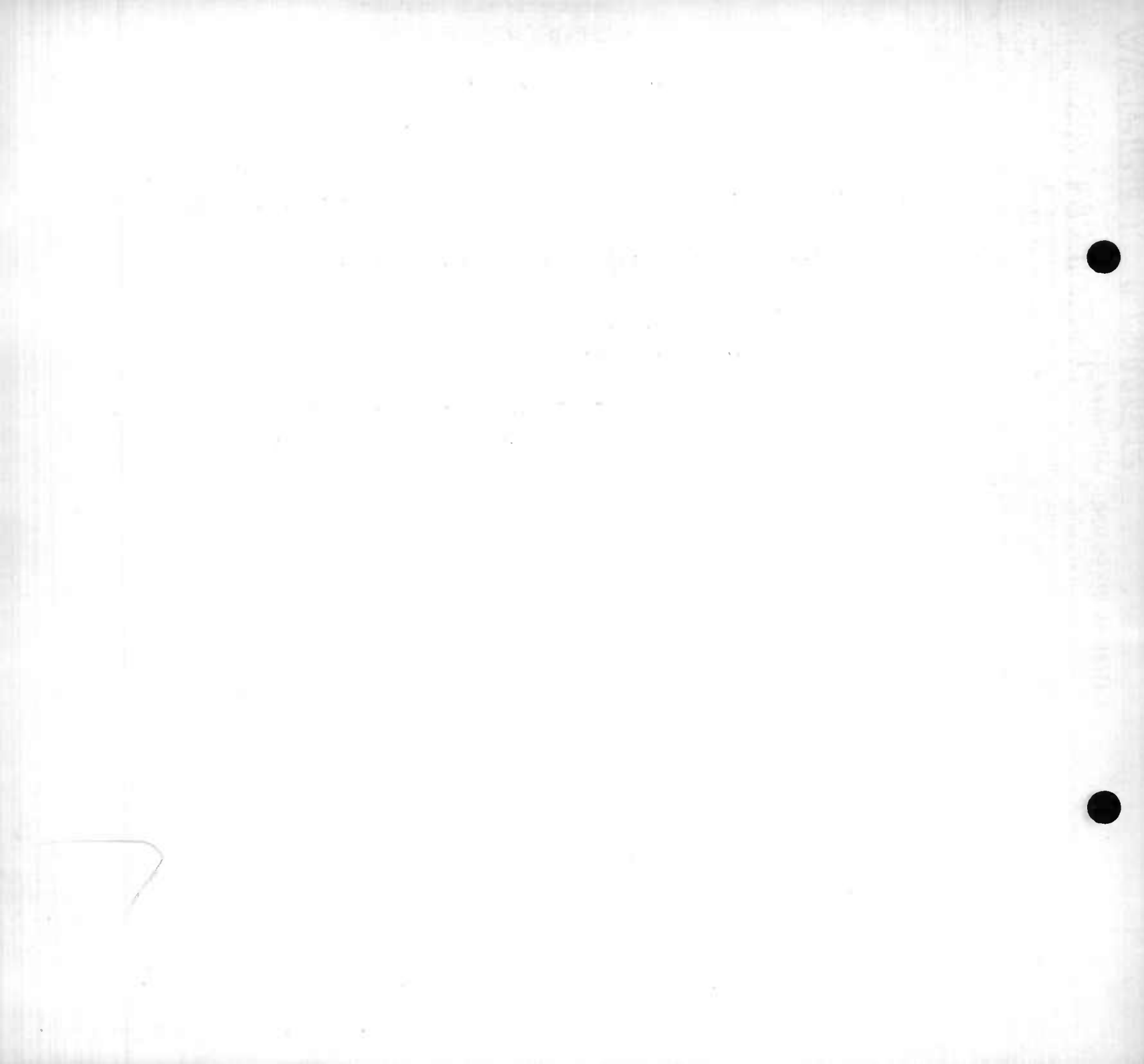
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5393					Registered No. 67 5393				
M.E. CASE NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) PUTS MRS. MARIE J.					2. DATE AND HOUR OF DEATH 6.2.1967 1 2 A-M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME & HOSP.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-02				
D. STREET ADDRESS (If rural, give location) 3113 GRINDON AVE-									
5. SEX F.	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6.26-95	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? AMER. U.S.		
13. FATHER'S NAME JOHN KAMMER					14. MOTHER'S MAIDEN NAME Jennie Hildebrand				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-05-0039		17. INFORMANT CHURCH HOME & HOSP.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X1 Cerebral Hemorrhage (C.V.A.) Hypertension & arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH one day many months				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5.31.1967 to 6.2.1967, that (I) (we) lost saw the deceased alive on 6.2.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Roderio M. Lim					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-2-67		
23C. PHYSICIAN'S NAME (Type) Roderio M. Lim					23D. ADDRESS Church Home & Hosp. Balto. Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67		24C. NAME of CEMETERY or CREMATORY Parkwood Cem.		24D. LOCATION (City, town or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR Balto., Md.				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

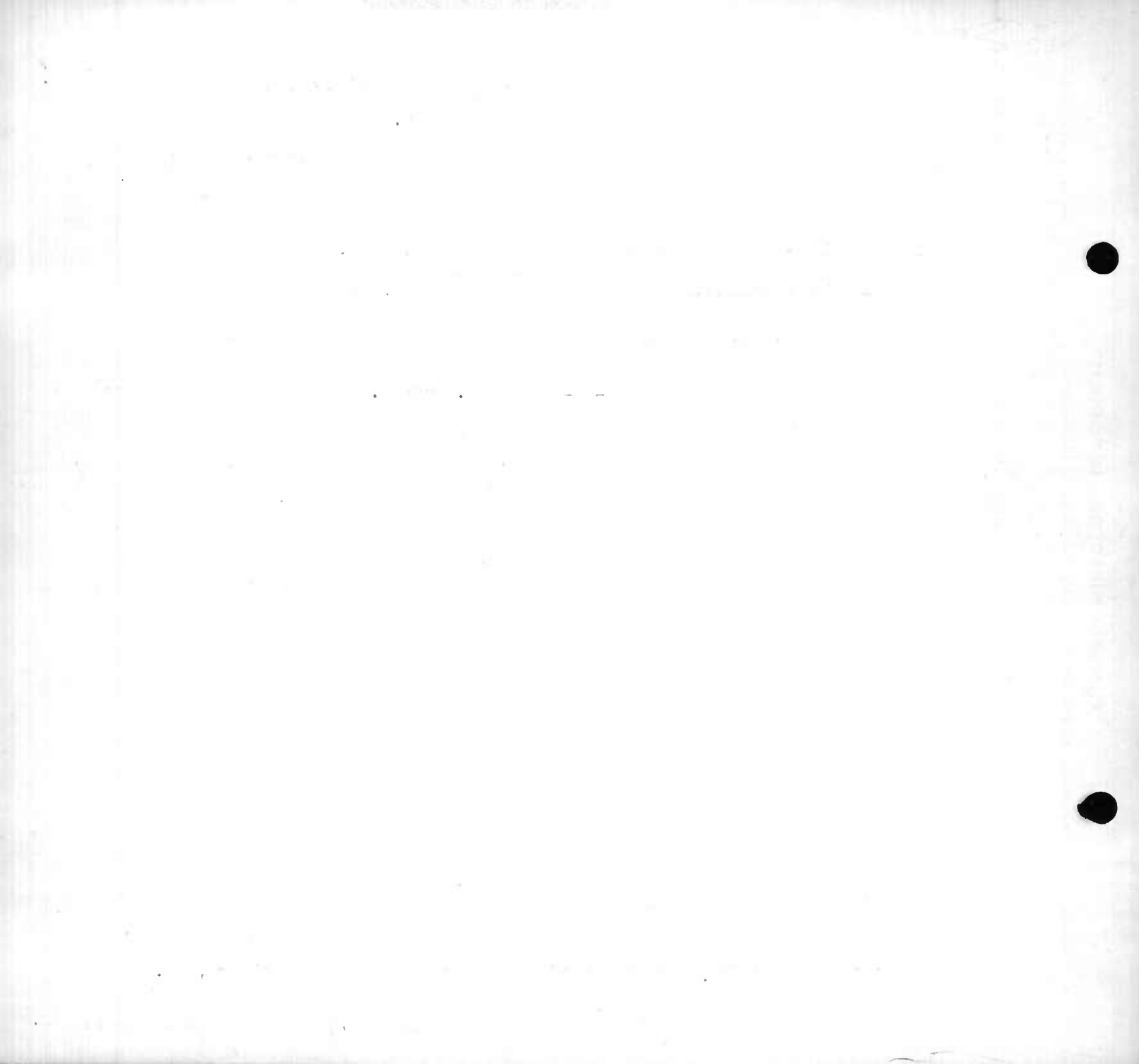
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5394		CERTIFICATE OF DEATH		67 5394	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) George H. Krauk, Jr.		2. DATE AND HOUR OF DEATH June 3, 1967 3 30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 3303 Ailsa Ave.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214			
		D. STREET ADDRESS (If rural, give location) 3303 Ailsa Avenue			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Apr. 10, 1900	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George H. Krauk, Sr.			14. MOTHER'S MAIDEN NAME Minnie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-42-7547	17. INFORMANT Mrs. Ruth Krauk		ADDRESS (Same)
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) arterio-sclerotic cardio-vascular disease acute coronary occlusion		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 years 1 day	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar 8 1967 to June 3 1967 , that (I) (we) last saw the deceased alive on May 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George Sawyer				23B. DATE SIGNED 6/5/67	
23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER		23D. ADDRESS 4808 HARFORD RD. Balto 14 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 6/7/67		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem.	
		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5395				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5395	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
John A. Asimakos				June 3, 1967 7 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Union Memorial Hospital				Md.			
5. SEX				6. RACE			
Male				White			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH			
widowed				April 6, 1892			
9. AGE (In years lost birthday)				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
75				Retired Lunch Counter			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Greece				USA			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Arthur Asimakos				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				219-32-9139			
17. INFORMANT				ADDRESS			
Mr. Gust J. Asimakos				(Same)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				1. Anteroseptal Heart Disease			
ANTECEDENT CAUSES				2. Enlarged Heart - Coronary Insufficiency			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				3. Coronary Failure			
II				4. Diabetes Mellitus			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				5. gent Arteriosclerosis			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from July 1, 1967 to June 3, 1967, that (I) (we) lost saw the deceased alive on May 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Donald W. Mintzer				6/5/67			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Donald W. Mintzer				3009 FIVE GREEN AVE BALTIMORE MD			
24A. BURIAL CREATION, REMOVAL (Specify)				24B. DATE			
Burial				6/6/67			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Greek Orthodox Cemetery				Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
JUN 5 1967				Robert E. Fackler, M.D.			
25C. FUNERAL DIRECTOR				ADDRESS			
Leonard J. Ruck Inc				Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5396		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Boucher, Lester H.		2. DATE AND HOUR OF DEATH 6-4-67 2:45 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp.		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21214 D. STREET ADDRESS (If rural, give location) 4609 Waltham Blvd.			
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify)	8. DATE OF BIRTH 12-11-79	9. AGE (In years last birthday) 87	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Walter Boucher		14. MOTHER'S MAIDEN NAME Almira Lichliter		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 175-16-9631		17. INFORMANT ADDRESS (Same) Mr. Thomas E. Grey	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		CAUSE OF DEATH (A) DUE TO Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-30-67 to 6-4-1967 , that (I) (we) last saw the deceased alive on 6-4-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE MIRIAM COHEN M.D.				23B. DATE SIGNED 6-4-67	
23C. PHYSICIAN'S NAME (Typo) MIRIAM COHEN				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/67		24C. NAME OF CEMETERY or CREMATORY Green Mountain Cemetery	
24D. LOCATION (City, town, or county) (State) Boulder, Colorado.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			

Myocardial infarction
Atherosclerotic cardiovascular disease

No

THE PUBLIC HEALTH SERVICE

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

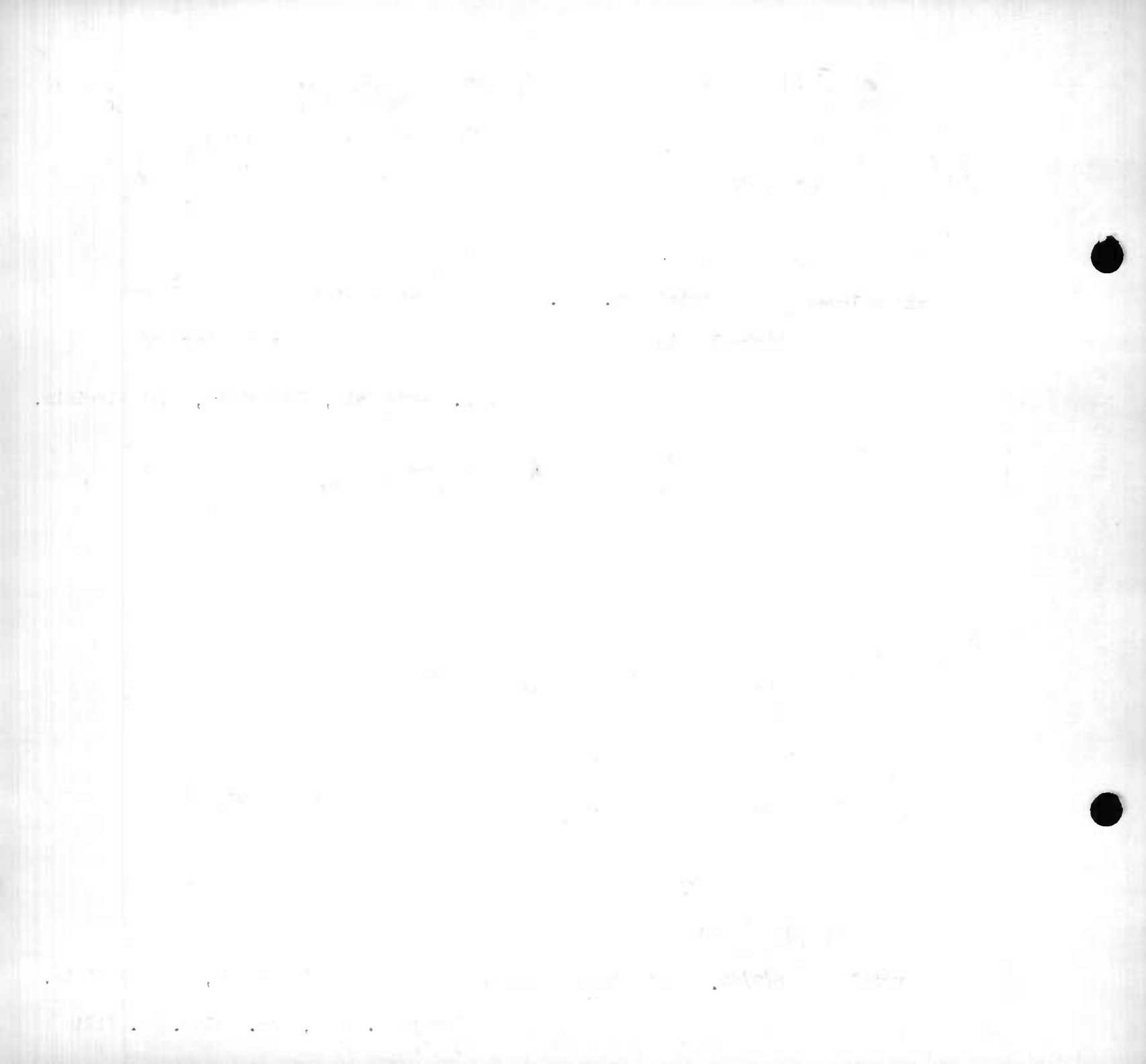
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5397	
BIRTH NO. 67 5397		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mr. Joseph T. De Legge		2. DATE AND HOUR OF DEATH 6/4/67 12:40 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		A. STATE 4117 White Ave 8. COUNTY Baltimore Md 21206			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY Ladies Garments		8. DATE OF BIRTH 01-05-84	
11. BIRTHPLACE (State or foreign country) Italy		9. AGE (in years last birthday) 83 yrs		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander De Legge		14. MOTHER'S MAIDEN NAME Carolyn Buzzelli		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 216-09-3344		17. INFORMANT Anthony DeLegge ADDRESS 5809 Cedonia Ave. Balto.			
18. 331X415313		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) PNEUMONIA, ASPIRATION DUE TO CVA		1 B. J. J. J.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Clinical DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CANCER OF Sigmoid Colon			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/3/67 to 6/4/67 , that (I) (we) last saw the deceased alive on 6/4/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sidney E. Kirkley M.D.				23B. DATE SIGNED 4 June 67	
23C. PHYSICIAN'S NAME (Type) DR SIDNEY E KIRKLEY M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/7/67		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) Balto., Md.		24E. LOCATION (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967	
25B. NAME OF REGISTRAR Robert E. Farkas		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.			

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5398		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5398	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CAIN, MARGARET Ann		6/3/67 10:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
SINAI HOSPITAL OF BALT		42		MARYLAND, BALT	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)		28-41	
BALTIMORE		3911 Gwynn Oak Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
F	W	NEVER MARRIED	6/9/32	34	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Employee		Social Sec. Adm.		West Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Michael Cain			Maude Sherwood		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Mrs. Maude Cain, Clarksburg, West Virginia.	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				6 mon?	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) Krukenberg's Tumor OF OVARY	
ANTECEDENT CAUSES				(B) DUE TO	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
35/23/67		BLOOD IN PERITONEUM		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5/17 1967 to 6/3 1967, that (I) (we) last saw the deceased alive on 6/3/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
David A. Spott				6/3/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
D. A. SPOTT				SINAI Hosp of BALT.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		6/7/67.		Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. CLERK'S SIGNATURE			
Clarksburg, West Virginia.		Leonard J. Ruck, Inc. Balto. Md. 21214			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 5 1967		Robert E. Johnson		5407	



1
A-45367 5399
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5399

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GLADYS V. ALLENDER

2. DATE AND HOUR PRONOUNCED DEAD

6-2-67

9:50 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1316 Homestead Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1316 Homestead Street 21218

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

10/17/1901

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Salad Maker

10B. KIND OF BUSINESS OR INDUSTRY

Minnick Sala ds

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John A. Wehrheim

14. MOTHER'S MAIDEN NAME

Hattie S. Base

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.
212-07-5001

17. INFORMANT

Alfred Kramer 8110 Long Point Rd. 22

ADDRESS

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic
disease

cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-2-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/6/67

23C. NAME of CEMETERY or CREMATORY

Loudon Pk. Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 5

1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto., Md.

ADDRESS

WALKER POLICE

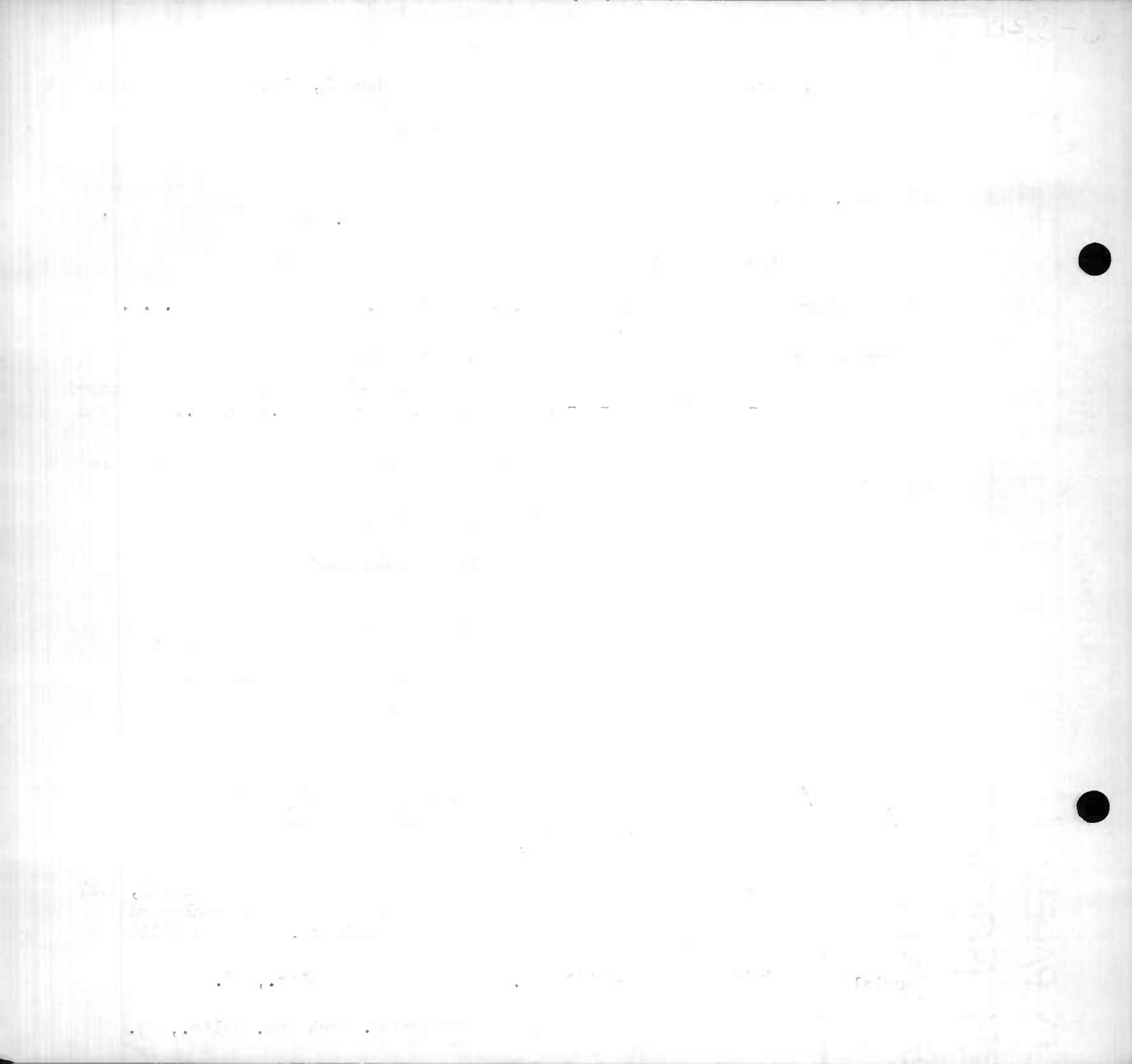
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. 67 5400
BIRTH NO. 67 5400		M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) JOHN M. SMITH			2. DATE AND HOUR OF DEATH 6/2/67 7:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21214 D. STREET ADDRESS (If rural, give location) 3300 Westfield Avenue			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3/25/00	9. AGE (In years last birthday) 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Displayman	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Displayman		10B. KIND OF BUSINESS OR INDUSTRY G. & E. Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BENJAMIN SMITH			14. MOTHER'S MAIDEN NAME MARY STOCKER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-3161		17. INFORMANT Mrs. Hazel M. Smith		
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY DEPRESSION DUE TO ASCVD @ INT. CAROTID OCCLUSION DUE TO CEREBRAL ISCHEMIA DUE TO PROBABLE ASPIRATION PNEUM.			INTERVAL BETWEEN ONSET AND DEATH ACUTE & CHRONIC			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PROBABLE ASPIRATION PNEUM.						
19A. DATE OF OPERATION NO		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes or No) NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (1) this hospital attended the deceased from 5/20/67 to 6/2/67 , that (1) we last saw the deceased alive on 6/2/67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. by (we) (did) (did not) view the body after death.						
23A. SIGNATURE B. Ominsky				23B. DATE SIGNED 6/2/67		
23C. PHYSICIAN'S NAME (Type) BARRY Ominsky		23D. ADDRESS MERCY HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/6/67		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967				
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto, Md. 21214				

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5401		BALTIMORE CITY HEALTH DEPARTMENT		67 5401	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) JONES, Paul Vernon		2. DATE AND HOUR OF DEATH June 1, 1967		8:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital Baltimore, Maryland 21218		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		12-03	
D. STREET ADDRESS (If rural, give location) 439 E 27th Street					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4/4/94	9. AGE (In years last birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Fighter
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Fighter		10B. KIND OF BUSINESS OR INDUSTRY Balto City Fire Dept		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Jones		14. MOTHER'S MAIDEN NAME Ida M Hardesty	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/25/17 - 6/2/19		16. SOCIAL SECURITY NO. 218-26-9720		17. INFORMANT ADDRESS Veterans Administration Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 260X + 163X Myocardial Infarction		CAUSE OF DEATH (A) DUE TO Diabetes Mellitus (B) DUE TO Carcinoma of left lung (C)		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Lung Disease			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from May 10th 1967 to June 1st 1967, that (1) (we) last saw the deceased alive on June 1st 1967 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (4/4/67) view the body after death.					
23A. SIGNATURE Allen Johnson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 1, 1967	
23C. PHYSICIAN'S NAME (Type) ALLEN JOHNSON		M.D. 23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/3/67		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem.	
24D. LOCATION Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 67 5402					CERTIFICATE OF DEATH					Registered No. 67 5402						
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) LEDLICH, LEO A.					2. DATE AND HOUR OF DEATH 6-3-67 1 A. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address, or location)					A. STATE Md					B. COUNTY						
48 Maryland General Hosp					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Baltimore 27-10						
					D. STREET ADDRESS (If rural, give location)					800 WINSTON AVE						
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married		8. DATE OF BIRTH 7-24-05		9. AGE (in years last birthday) 61		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER					10B. KIND OF BUSINESS OR INDUSTRY WAVERLY PRESS					11. BIRTHPLACE (State or foreign country) Baltimore, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Ledlich					14. MOTHER'S MAIDEN NAME Pauline											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 216-07-0043					17. INFORMANT MRS. ANNE S. LEDLICH (SAME)					ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) Cardiac arrest					INTERVAL BETWEEN ONSET AND DEATH 20 minutes						
ANTECEDENT CAUSES					(B) Asystole					Unknown						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) ASCVD					Unknown						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										CV thrombosis						
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 5/30 1964 to 6-3 1967, that (I) (we) last saw the deceased alive on 6-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE Timothy K Gray					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 6-3-67						
23C. PHYSICIAN'S NAME (Type) TIMOTHY K GRAY					M.D.					23D. ADDRESS MARYLAND GENERAL HOSP						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 6/6/1967					24C. NAME of CEMETERY or CREMATORY Holy Redeemer					24D. LOCATION (City, town, or county) Baltimore, (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967					25B. NAME OF REGISTRAR Robert E. Jenkins					25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.						



67 5403
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5403

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Frederick W. Carroll, Sr.

2. DATE AND HOUR PRONOUNCED DEAD

June 3, 1967

1:30 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 81212

D. STREET ADDRESS (If rural, give location)

812 Benninghaus Rd.

5. SEX

M

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1/13/1894

9. AGE (In years lost birthday)

73

10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Retired-Lieut. Detective

Balto. Police Dept.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lewis Carroll

14. MOTHER'S MAIDEN NAME

Pauline Giest

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

213-28-2312

17. INFORMANT

Frederick W. Carroll, Jr. 5 Severn Rd.

ADDRESS Severna Pk, Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio cardio-vascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 4, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6/7/1967

23C. NAME of CEMETERY or CREMATORY

Lorraine Park

23D. LOCATION (City, town, or county) (State)

Woodlawn, Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 5 1967

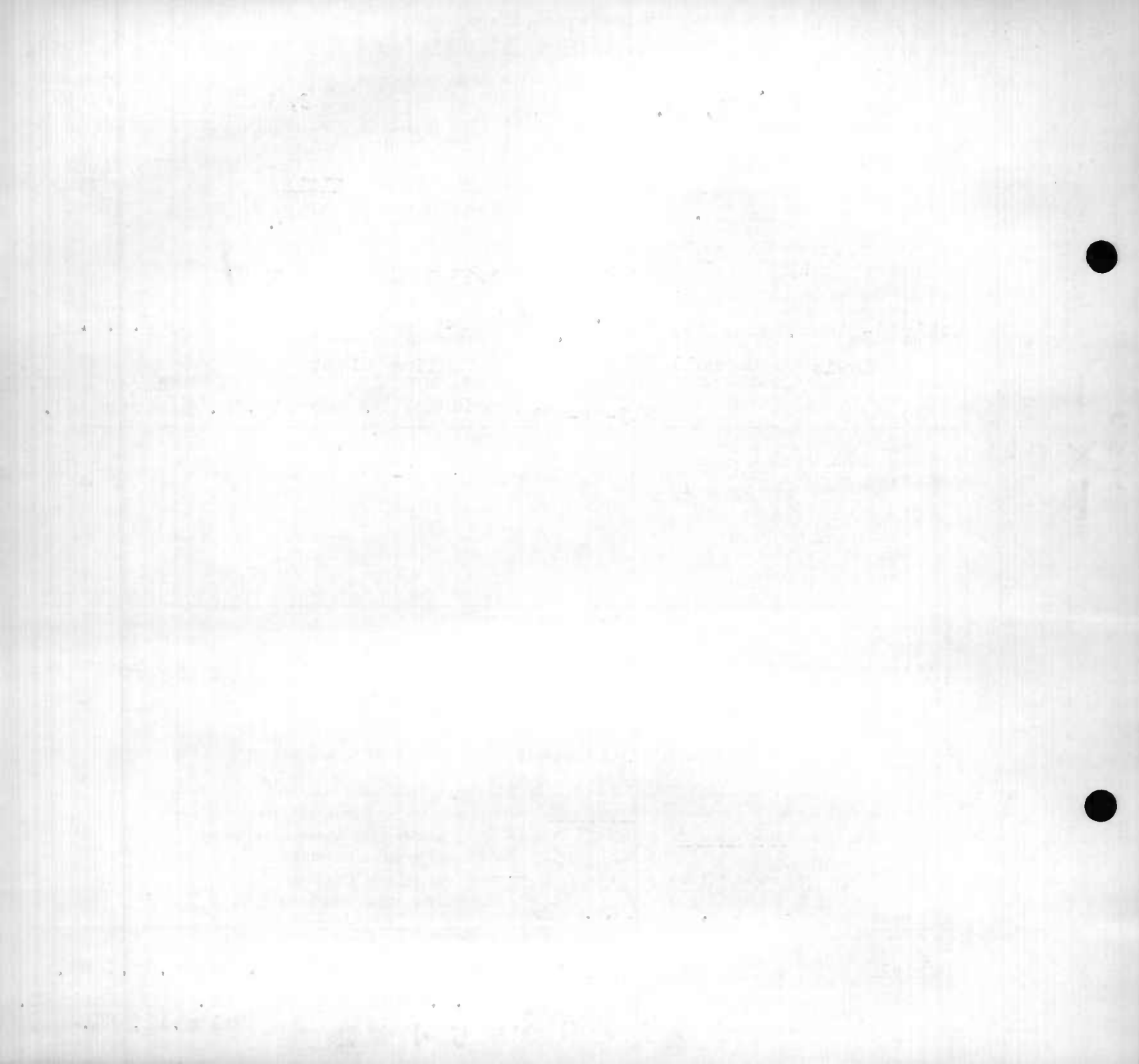
24B. NAME OF REGISTRAR

Robert E. Ferguson

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.

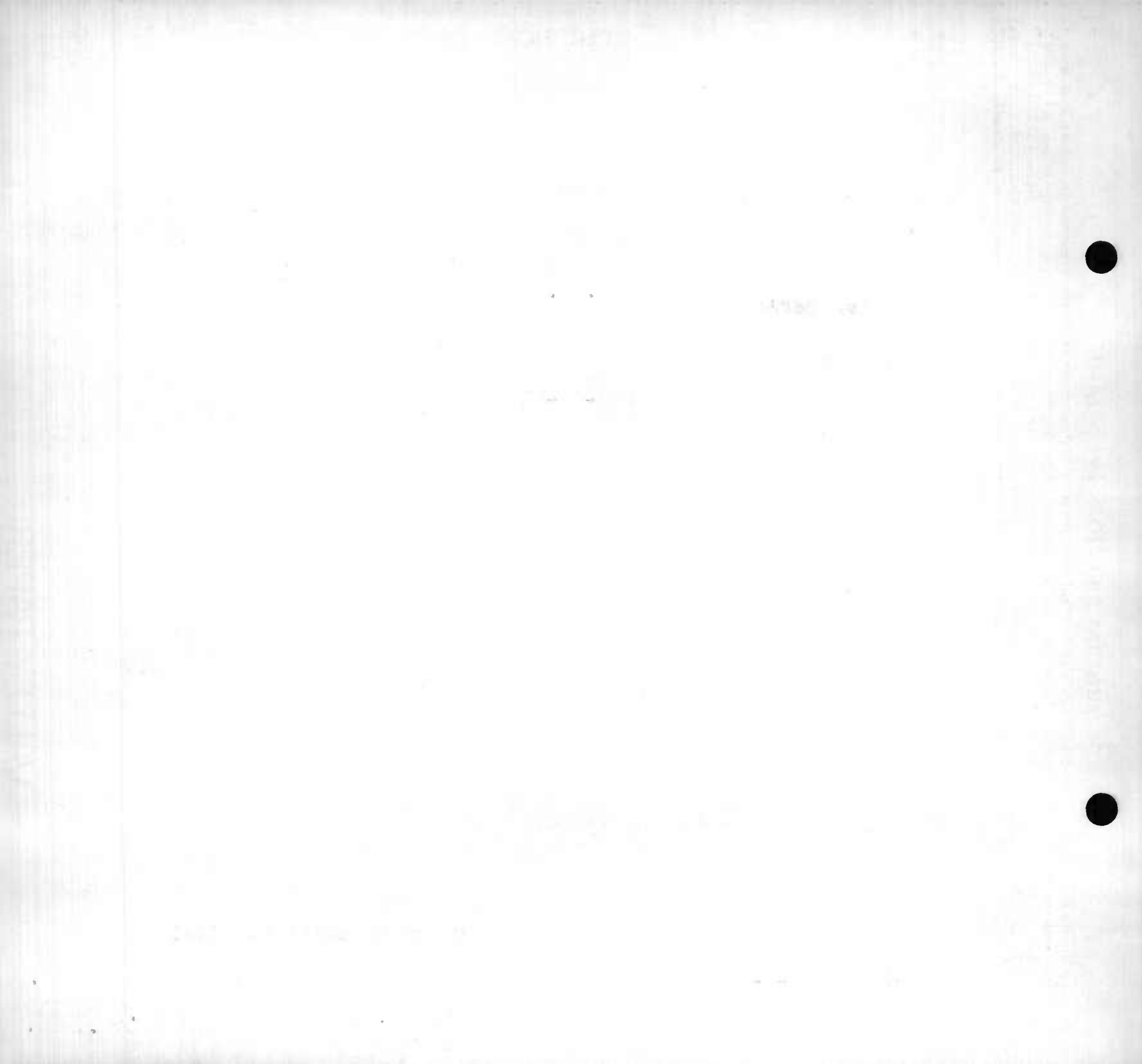
Balto. 12, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5404		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5404	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) THREADGILL, JOHN HUGH			2. DATE AND HOUR OF DEATH 12:20 pm. June 1, 1967 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 332 St. Dunstan's Road		
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 08-22-94	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive Ret'd		10B. KIND OF BUSINESS OR INDUSTRY U.S. Steamship Lines		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? American			13. FATHER'S NAME Daniel Edward Threadgill		
14. MOTHER'S MAIDEN NAME Mary Moore			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 213-05-4189			17. INFORMANT Floretta T. Jones ADDRESS 283 Alvarado Ave. Los Altos.		
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Diabetes mellitus DUE TO (B) Dehydration. DUE TO (C) ASCV D		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12:25 pm May 31 19 67 to 12:20 pm June 1 19 67 , that (I) (we) last saw the deceased alive on 12:20 pm June 1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sang Won Song			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 1, 1967
23C. PHYSICIAN'S NAME (Type) Sang Won Song			23D. ADDRESS M.D. Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-3-67		24C. NAME OF CEMETERY or CREMATORY Jessops Methodist Church Cemetery	
24D. LOCATION (City, town, or county) Sparks,		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co ADDRESS 21212 4905 York Road Balto., Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5405		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5405	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Daniels, Thomas Farrell			2. DATE AND HOUR OF DEATH 6/2/1967 Mid night M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 33rd & Calvert Sts. Balto. Md. 21218			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-12		
D. STREET ADDRESS (If rural, give location) 5210 Tilbury Way					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/6/1898	9. AGE (In years lost birthday) 68	10. If Under 1 Yr. Months; Days 11 Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		10B. KIND OF BUSINESS OR INDUSTRY MEDICAL		11. BIRTHPLACE (State or foreign country) Savannah, Ga.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Thomas Francis Daniels		14. MOTHER'S MAIDEN NAME Mary Fianell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 720-44-8288		17. INFORMANT Mrs. Nancy G. Daniels. 5210 Tilbury way Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH ③ Laennec's (portal) cirrhosis of the Liver & hepatic failure ④ Cardiac failure ① INTRA-PERITONEAL HEMORRHAGE ② STATUS POST PORTAL-CAVAL SHUNT		
19A. DATE OF OPERATION 5/27/1967			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED portal caval shunt		20A. AUTOPSY? (Yes or No) yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from June 1, 4/23/1967 to 6/1 1967, that (I) (we) lost saw the deceased alive on June 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sang-Kyun Shin			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-2-1967
23C. PHYSICIAN'S NAME (Type) SANG-KYUN SHIN			23D. ADDRESS THE UNION MEMORIAL HOSPITAL Union Mem. Hosp. Balto. Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-5-67		24C. NAME OF CEMETERY OR CREMATORY New CATHEDRAL	
24D. LOCATION (City, town, or county) (State) BALTO. MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Charles E. Taylor	
25C. FUNERAL DIRECTOR J.H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 YORK RD			

SHIN KIM SHIN

SHIN KIM SHIN

1/20/74

0/1

2/27/74 Post Card about

for

SHUNT

② STATUS POST POTAL-CAVAL

① INTA-PERITONEAL HEMORRHAGE

④ Carotid fracture

the time of impact

③ Fracture of the base of the skull

the day of death

2/10/74

THOMAS FRANKLIN

2/10/74

11/8/73

2/10/74

2/10/74

2/10/74

W-410

67 5406

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5406

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELIZABETH WOLF

2. DATE AND HOUR PRONOUNCED DEAD

June 1, 1967

8:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

MARYLAND GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3429 University Place

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

11/23/99

9. AGE (In years
last birthday)

67

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John H. Vincent

14. MOTHER'S MAIDEN NAME

Marjorie Starrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-46-7198

17. INFORMANT

ADDRESS

J.E. Harold 1508 1st Nat'l. Bank Bldg.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A)
DUE TO

Bronchopneumonia

cerebral anoxia due to
laryngeal obstruction
(aspiration of food)(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Governor's Club

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

1123 N. Eutaw Street

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5 4 67

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

aspiration of food

22.

I certify that I held an Inquiry ☒ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 2, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-5-67

23C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Woodlawn Balto. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

JUN 5 1967

24B. NAME OF REGISTRAR

Robert E. Fagbema

24C. FUNERAL DIRECTOR

Henry W. Jenkins & Sons Co. 21212
4905 York Road Balto., Md.

ADDRESS

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 57TH STREET
CHICAGO, ILL. 60637

P-100

BALTIMORE CITY HEALTH DEPARTMENT						
BIRTH NO. 67 5407		MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5407				
M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) CURTIS H. POFF		2. DATE AND HOUR PRONOUNCED DEAD June 3, 1967 11:20 P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY York C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) York D. STREET ADDRESS (If rural, give location) 222 W. Kurtz Avenue				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH July 13, 1905			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY Bendix Corp. Fuzing Devices Div.	9. AGE (In years last birthday) 61			
11. BIRTHPLACE (State or foreign country) Wrightsville, Pa.		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Harvey Poff		14. MOTHER'S MAIDEN NAME Mary Shaw				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 188-03-2846	17. INFORMANT Mrs. Minnie I. Poff ADDRESS same address			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Traumatic Injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? U.S. Route 29, 200 Ft. south of State Route 108		
21D. TIME OF INJURY (APPROX.) 6/3/67 9:34 A.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? auto-auto collision		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/4/67						
23A. BURIAL CREMATION, REMOVAL (Specify) Removal		23B. DATE 6/5/1967	23C. NAME of CEMETERY or CREMATORY Highmount Cemetery		23D. LOCATION (City, town, or county) (State) Hellam Township York Co., Pa.	
24A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		24B. NAME OF REGISTRAR Robert E. Fairbank		24C. FUNERAL DIRECTOR Wm. J. Tipton & Sons ADDRESS Dalt., Md.		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5408		BALTIMORE CITY HEALTH DEPT.		REGISTERED NO. 67 5408	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>John M. Stewart</u>			2. DATE AND HOUR OF DEATH <u>5/31/67</u> <u>11:20</u> P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>441 Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Gaywood</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>6441 Blenheim Rd #12</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>8-4-89</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Business Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>known</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>	
13. FATHER'S NAME <u>John Stewart</u>			14. MOTHER'S MAIDEN NAME <u>Eleanor Little</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>195-05-9790</u>		17. INFORMANT <u>Patient's chart</u> ADDRESS	
18. <u>522X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <u>Acute Pulmonary Edema</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <u>5/31</u> <u>1967</u> to <u>5/31</u> <u>1967</u> , that (B) (we) last saw the deceased alive on <u>5/31</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John R. Vaughn, Jr.</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/31/67</u>
23C. PHYSICIAN'S NAME (Type) <u>JOHN R. VAUGHN, JR.,</u>			23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>6/2/1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Talbot & Son with 112</u> ADDRESS <u>Balto. Md.</u>	

John Stewart

Thomas Stewart

John Stewart

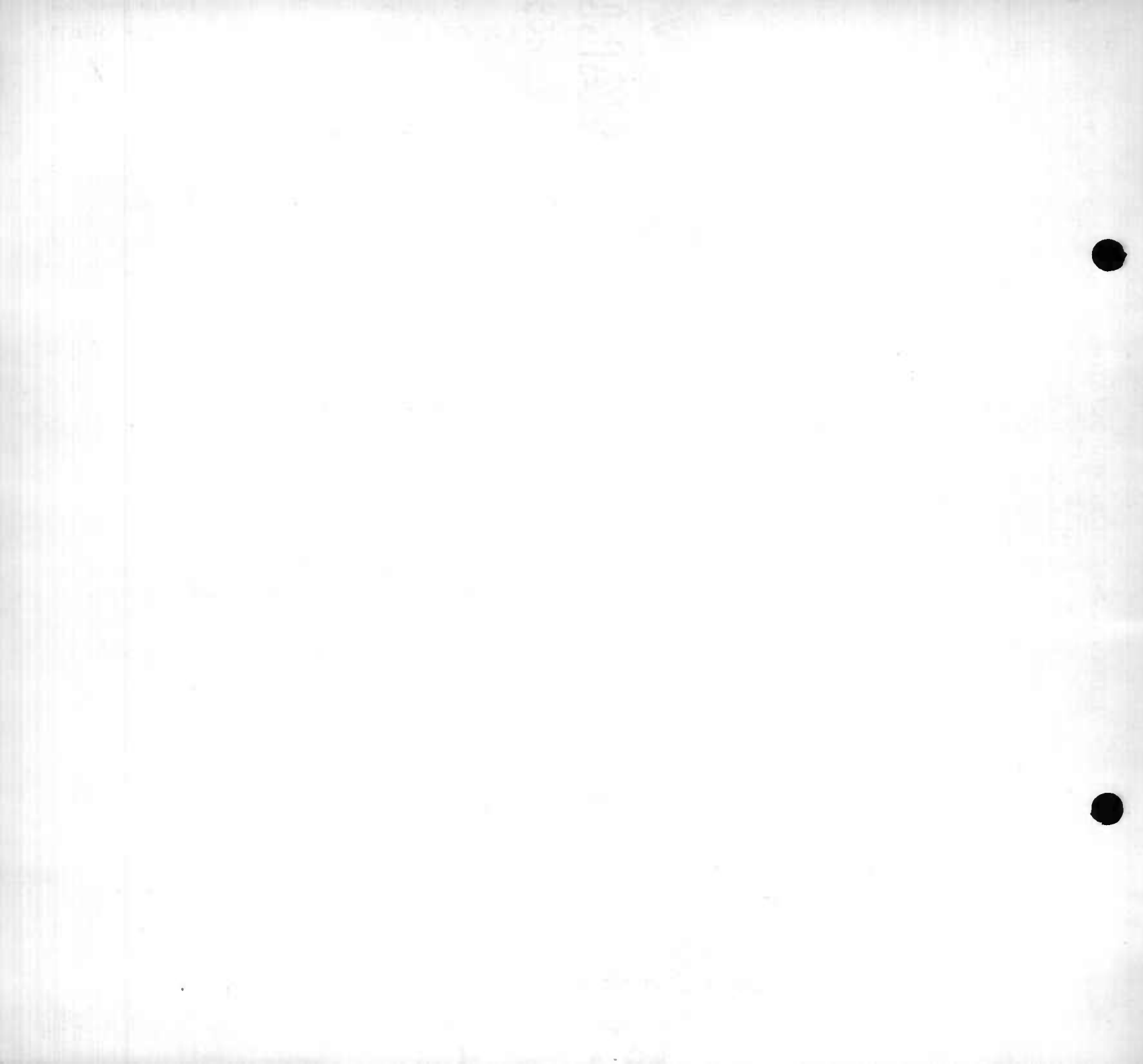
John Stewart

John Stewart

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5409	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 5409 CERTIFICATE OF DEATH </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) DONALD DUSHMAN			2. DATE AND HOUR OF DEATH 31 MAY 1967 11:40 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY of MARYLAND </div> <div> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 9-04 D. STREET ADDRESS (If rural, give location) 616 E 30th ST - BALT.		
5. SEX M	6. RACE CAUC	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED & SEPARATED	8. DATE OF BIRTH 11-8-42	9. AGE (In years last birthday) 24	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRY-WALL MECHANIC			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME TYLER DUSHMAN			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS University Hospital Records
18. 201X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HODGKINS DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO PANCYTOPENIA 2nd A (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 YEAR
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) ?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 31 MAY 1967 to 31 MAY 1967 , that (I) (we) last saw the deceased alive on 31 MAY 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard P Wenzel M.D.				23B. DATE SIGNED 31 MAY 1967	
23C. PHYSICIAN'S NAME (Type) RICHARD P. WENZEL M.D.		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/1/1967		24C. NAME of CEMETERY or CREMATORY Temple Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Castlewood, Va.					
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Wm. J. Jackson	
ADDRESS Baltimore, Md.					



1
B-636

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **67 5410** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 5410**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **CHARLES A. BERTRAND** 2. DATE AND HOUR PRONOUNCED DEAD **June 1, 1967 7:15 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
00 5318 Ethelbert Avenue **Baltimore** **27-17**

D. STREET ADDRESS (If rural, give location) **5318 Ethelbert Avenue 15**

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Married** 8. DATE OF BIRTH **Nov. 23, 1906** 9. AGE (In years last birthday) **60** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Never worked** 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Lynn, Mass.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Willard C. Bertrand** 14. MOTHER'S MAIDEN NAME **Lula M. Durell**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) **No None** 16. SOCIAL SECURITY NO. **218-07-4818** 17. INFORMANT **Mrs. Theresa C. Bertrand same address** ADDRESS

18. **420.0** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) **Arteriosclerotic heart disease** DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **June 1, 1967**

EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **6/5/1967** 23C. NAME of CEMETERY or CREMATORY **Woodlawn Cemetery** 23D. LOCATION (City, town, or county) (State) **Woodlawn, Md.**

24A. DATE REC'D BY HEALTH DEPT. **JUN 5 1967** 24B. NAME OF REGISTRAR **Robert E. Finkbeiner** 24C. FUNERAL DIRECTOR **Wm. J. Tichner & Sons with L.P.A.** ADDRESS **Balto., Md.**

VS 151-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>67 5411</u>	
BIRTH NO. <u>67 5411</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mrs. EDWINA M. GUSDORFF</u>		2. DATE AND HOUR OF DEATH <u>6-2-67</u> <u>1³⁰</u> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>Bow Secours Hospital</u> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
5. SEX <u>FEMALE</u>				6. RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>12-17-84</u>	
13. FATHER'S NAME <u>BENJAMIN F. MILLER</u>				14. MOTHER'S MAIDEN NAME <u>EDWINA ?</u>		9. AGE (in years last birthday) <u>82</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-22-3633</u>		17. INFORMANT <u>Mr. Wm. E. Weaver</u> ADDRESS <u>Alamo Court Rt. 50 Ocean City, Md.</u>	
18. <u>45 IX I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <u>Perforation of Abdominal Aorta</u> DUE TO <u>Aneurysm, Arteriosclerotic, with Rupture Peritoneal Hemorrhage</u> (B) <u>Generalized Arteriosclerosis</u> DUE TO (C) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (If) (this hospital) attended the deceased from <u>JUNE 2</u> 19 <u>67</u> to <u>JUNE 2</u> , 19 <u>67</u> , that (If) (we) last saw the deceased alive on <u>JUNE 2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Adolfo G. de Perio</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23B. DATE SIGNED <u>June 2, 1967</u>		23C. PHYSICIAN'S NAME (Type) <u>ADOLFO G. DE PERIO</u> M.D.		23D. ADDRESS <u>Bow Secours Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	
24B. DATE <u>6/5/1967</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1967</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm. A. Tichenor</u>		25D. ADDRESS <u>Baltimore, Md.</u>			

19-10-19

The results of the analysis of the
specimens of the material
submitted for analysis are as follows:
The results of the analysis of the
specimens of the material
submitted for analysis are as follows:

1
S-000

67 5412

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5412

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LUTHER

FULTON

SEAY Jr.

2. DATE AND HOUR PRONOUNCED DEAD

June 2, 1967

3:50 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

ST. AGNES HOSPITAL (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Virginia

Mecklenburg

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt. Skipwith

D. STREET ADDRESS (If rural, give location)

Route #1, Chase City, Virginia

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

July 31, 1946

9. AGE (In years
last birthday)

20 21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Construction worker

10B. KIND OF BUSINESS OR INDUSTRY

road building

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Luther Fulton Seay Sr.

14. MOTHER'S MAIDEN NAME

Delma Edmonds

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Hospital Records

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Bridge

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

5000 Block River Road - Howard County

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6/2/67 3:15 P.

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Fell 130 ft. from a bridge. 63-00

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6/3/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

6/3/1967

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Chase City Va.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

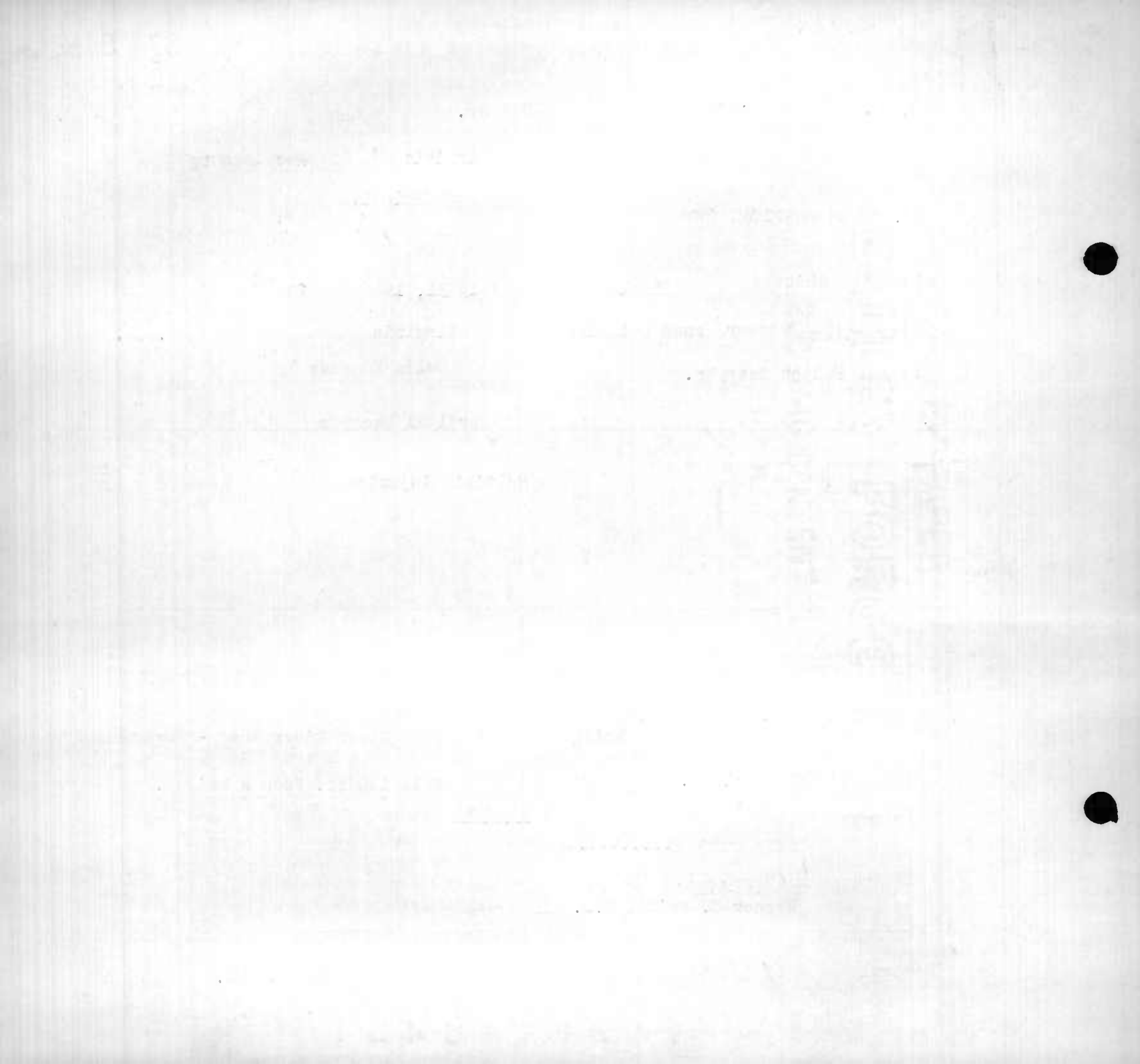
24C. FUNERAL DIRECTOR

ADDRESS

JUN 5 1967

Werner U. Spitz, M.D.

William J. Zickner & Son North & Pa. Ave.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		Registered No.	
BIRTH NO.		67 5413		CERTIFICATE OF DEATH		67 5413	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) ELIZABETH VAN NESS				2. DATE AND HOUR OF DEATH 6-3-67 4⁵⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL				A. STATE NEW JERSEY			
(If not in hospital or institution, give street address or location)				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) CEDARGROVE V-27			
				D. STREET ADDRESS (If rural, give location) 59 BRUNSWICK ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-10-01	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADELBERT YOUNG				14. MOTHER'S MAIDEN NAME EDITH BADGELEY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records		ADDRESS	
18. 416 XH 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) intractable CHF ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RHD				CAUSE OF DEATH (A) intractable CHF DUE TO (B) RHD DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 8 days 38 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. diabetes mellitus							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from May 19 1967 to June 3 1967 , that (we) last saw the deceased alive on June 3 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE Daniel C. Hadlock M.D.				23B. DATE SIGNED 6-3-67		23C. PHYSICIAN'S NAME (Type) DANIEL C. HADLOCK M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 6/5/67		24C. NAME OF CEMETERY OR CREMATORY Prospect Hill		24D. LOCATION (City, town, or county) (State) Caldwell N.J.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Jack Lewis Inc		ADDRESS 2100 Entaw Place	

2230 684 47-092-2

Y 2230 684

Y 2230 684

8 days
30 years

intricate C4F
K 47

diabetes mellitus

June 3 1963
June 3 1963

Daniel C. Harker
Daniel C. Harker
X
6-3-63

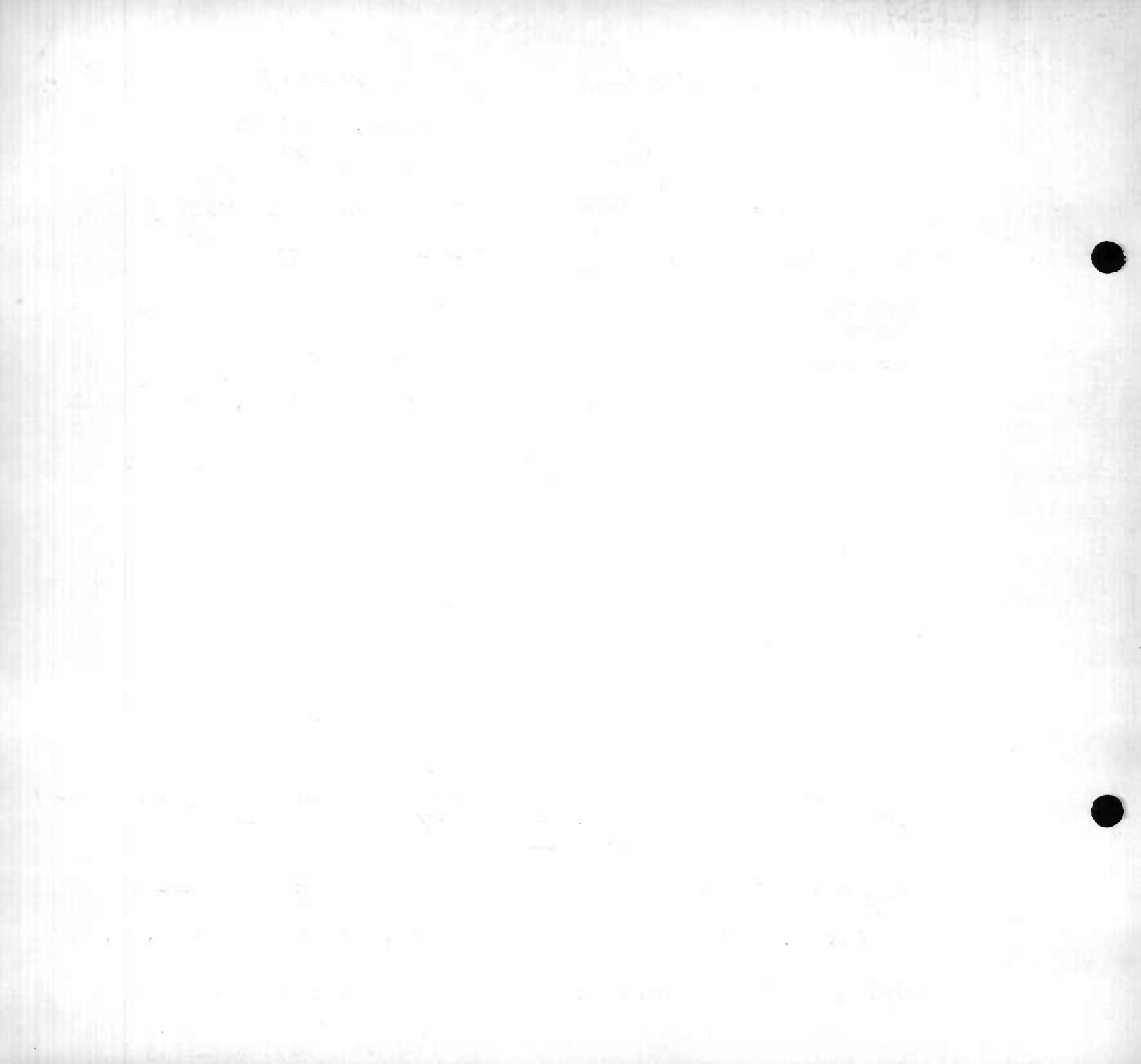
CERTIFICATE OF DEATH

Registered No.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Josephine Winkelman</i>		2. DATE AND HOUR OF DEATH <i>6-2-67</i> <i>5:05</i> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> , B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland #21224</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>53-00</i>			
D. STREET ADDRESS (If rural, give location) <i>1969 Snyder Avenue #21222</i>							
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>		8. DATE OF BIRTH <i>11-25-89</i>	9. AGE (In years lost birthday) <i>77</i>	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Nator Weeks</i>				14. MOTHER'S MAIDEN NAME <i>Martha Oliver</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>BCM 4940 Eastern Avenue</i> <i>RECORDS: Baltimore, Maryland #21224</i>	
18. <i>15-3-81</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Metastatic Carcinoma of Colon</i> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that at (this hospital) attended the deceased from <i>5-3</i> 19 <i>67</i> to <i>6-2</i> 19 <i>67</i> , that at (we) last saw the deceased alive on <i>6-2</i> 19 <i>67</i> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.							
23A. SIGNATURE <i>James T. Corkins</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <i>6-2-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>James T. Corkins</i>				23D. ADDRESS M.D. <i>4940 Eastern Avenue Baltimore, Md. #21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/5/67</i>		24C. NAME of CEMETERY or CREMATORY <i>Mount Carmel</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 5 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>HENRY SANDER & SONS INC.</i>		ADDRESS <i>Baltimore, Maryland 21213</i>	



1
H-560

67 5415

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 5415

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES A. HENRY

2. DATE AND HOUR PRONOUNCED DEAD

6-4-67

10:50 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)2621 CHESTERFIELD AVENUE - Amb. Crew
Off. Heid

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2621 Chesterfield Avenue 21213

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

7/1/'93

9. AGE (In years
last birthday)

80x 73

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Gardener

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James A. Henry, Sr.

14. MOTHER'S MAIDEN NAME

Elizabeth Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

220-14-2037

17. INFORMANT

ADDRESS

John E. Henry 821 E. 47th St.

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-5-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/7/'67

23C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

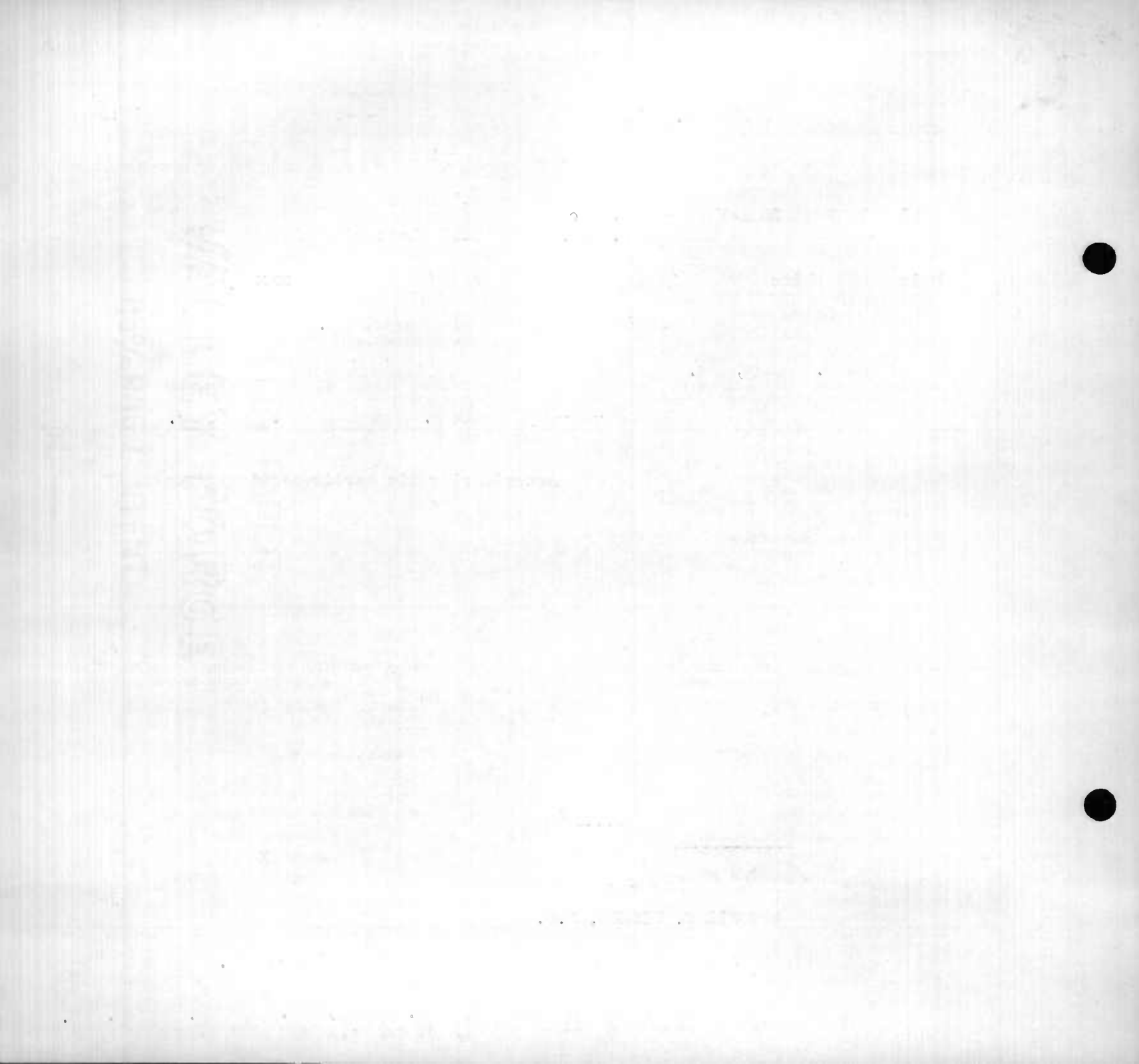
24C. FUNERAL DIRECTOR

ADDRESS

JUN 5 1967

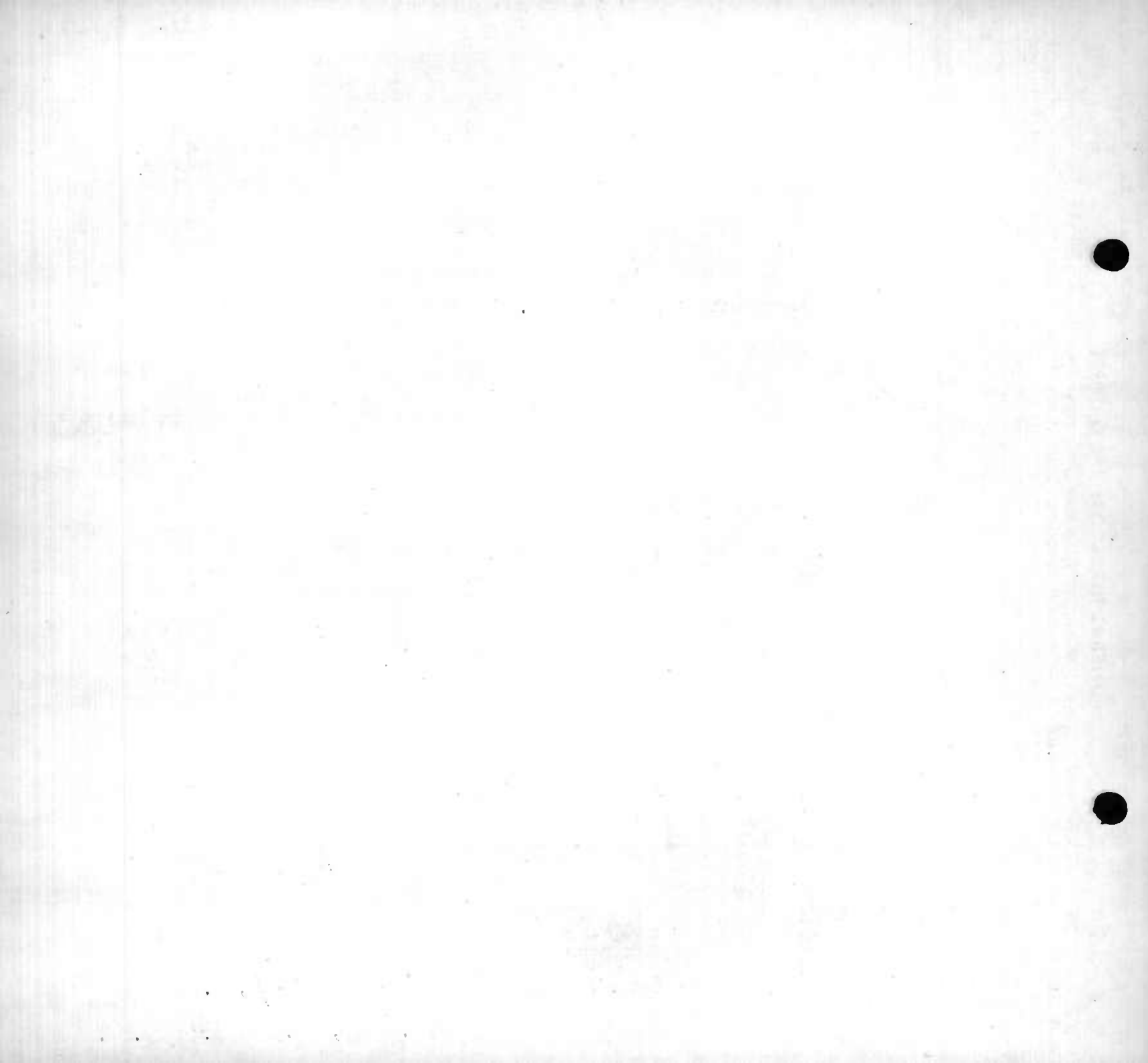
John A. Morap, Inc. 3000 E. Balto. St.

John A. Morap, Inc. 3000 E. Balto. St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5416				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5416	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HOWARD F. HARTMAN				2. DATE AND HOUR OF DEATH JUNE 2, 1967 2:50 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSP.		(If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21224 602			
				D. STREET ADDRESS (If rural, give location) 106 N. GLOVER ST			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 1-2-1898	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED (Hauptfleur Oil refining Co.)				10B. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM HARTMAN				14. MOTHER'S MAIDEN NAME FLORENCE SMITH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN WWI				16. SOCIAL SECURITY NO. 216-05-2507		17. INFORMANT ADDRESS CECELIA HARTMAN - WIFE - SAME	
18. 1810 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) TRANSITIONAL CELL CARCINOMA YEARS OF BLADDER				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC RENAL DISEASE YEARS							
19A. DATE OF OPERATION 5-12-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EXCISION OF TUMOR		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>April 29, 1967</u> to <u>June 2, 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>JUNE 2, 1967</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles S. Harrison				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-2-67	
23C. PHYSICIAN'S NAME (Type) CHARLES S. HARRISON				23D. ADDRESS MARYLAND GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR D. O. B. E. Talley		25C. FUNERAL DIRECTOR John A. Morley, Inc.		ADDRESS 3000 E. Balto. St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5417	
BIRTH NO. 67 5417		M.E. CASE NO. A.			
1. NAME OF DECEASED (Type or Print) JOSEPH WHITMORE			2. DATE AND HOUR OF DEATH 6:20 P.M. 15-31-67 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME AND HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3616 GWYNNOAK AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11-19-94	9. AGE (In years lost birthday) 72	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES
13. FATHER'S NAME JOHN WHITMORE			14. MOTHER'S MAIDEN NAME ALICE SPINGER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWI Army		16. SOCIAL SECURITY NO. 813-03-8510	17. INFORMANT ADDRESS MARY E Whitmore - Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Old Tuberculosis		CAUSE OF DEATH (A) DUE TO Old Tuberculosis (B) DUE TO Pulmonary Emphysema (C) Arteriosclerotic Heart Disease - Chronic Failure		INTERVAL BETWEEN ONSET AND DEATH yes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus		yes	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12:45pm 5-31-1967 to 6:20pm 5-31-1967 , that (I) (we) last saw the deceased alive on 5-31-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Baltazar Jr.				23B. DATE SIGNED 5/31/67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR JR.		23D. ADDRESS CHURCH HOME & HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6-5-67	24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Ellsworth Armacost		25C. FUNERAL DIRECTOR ADDRESS -4600 Liberty Hgts.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
P-632 67 5418					CERTIFICATE OF DEATH					Registered No. 67 5418					
BIRTH NO.					M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH										
Carl Pritchett					June 2, 1967					8 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)										
FULL NAME OF HOSPITAL OR INSTITUTION					A. STATE					B. COUNTY					
(If not in hospital or institution, give street address or location)					Maryland					Baltimore					
00 3012 Wayne Avenue					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Baltimore					
					D. STREET ADDRESS (If rural, give location)					28-02					
3012 Wayne Avenue					3012 Wayne Avenue										
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
M		white		married		10-7-1895		71		Buyer		Bischofs Head, Md		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME										
Z Pritchett					MARTHA Pritchett										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
U.S. Army					212-05-6607					FLORENCE S Pritchett - Same					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
156.11					(A) Carcinoma of Liver					6 months					
ANTECEDENT CAUSES					(B) DUE TO										
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C) DUE TO										
II															
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
2 none		✓		yes		yes									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)									
No		none		none											
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?											
✓		While At Work		✓											
22. I certify that (I) (this hospital) attended the deceased from Dec 5 1966 to June 2 1967, that (I) (we) last saw the deceased alive on May 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE					23B. DATE SIGNED										
Lay Martin					June 3, 1967										
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS										
Lay Martin					1201 Calvert St Baltimore Md 21202										
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)									
Burial		6-6-67		Loudon Park Cemetery		Baltimore, Md									
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS									
JUN 5 1967		P. J. E. Edwards		E. H. Swarth		Armacost 4600 Liberty Hgts Ave									



THE BODY OF PAMELA BROMWELL WAS RELEASED ON APPROVAL BY **FUNERAL DIRECTOR: IMPORTANT** EXAMINERS OFFICIAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5419		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5419	
M.E. CASE NO. 66-19882		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) Bromwell, Pamela		2. DATE AND HOUR OF DEATH 31 May 1967		5:00 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE MARYLAND B. COUNTY Balto. Co.	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		D. STREET ADDRESS (If rural, give location) 53-00	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9-14-66	
13. FATHER'S NAME RONALD BROMWELL		14. MOTHER'S MAIDEN NAME PATRICIA TATE TAYLOR		9. AGE (In years last birthday) 8 25	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		11. BIRTHPLACE (State or foreign country) BALTIMORE	
17. INFORMANT RONALD BROMWELL		ADDRESS 3739 SYLVAN DR.		12. CITIZEN OF WHAT COUNTRY? MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(A) Cardiac Arrest		45 min.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) Pulmonary Banding		7 min.	
19A. DATE OF OPERATION 5-31-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ventricular Septal Defect		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that X (this hospital) attended the deceased from May 31 19 67 to May 31 19 67 , that X (we) last saw the deceased alive on May 31 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. W (We) (did) (did not) view the body after death.		23A. SIGNATURE R. A. MARRESE M.D.		23B. DATE SIGNED May 31, 1967	
23C. PHYSICIAN'S NAME (Type) R. A. MARRESE		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION	
24B. DATE 6-1-67		24C. NAME of CEMETERY or CREMATORY LOUDON PARK CREMATORY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 5 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ELSWORTH ARMACOST	
				ADDRESS 464 Liberty Hgts.	

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

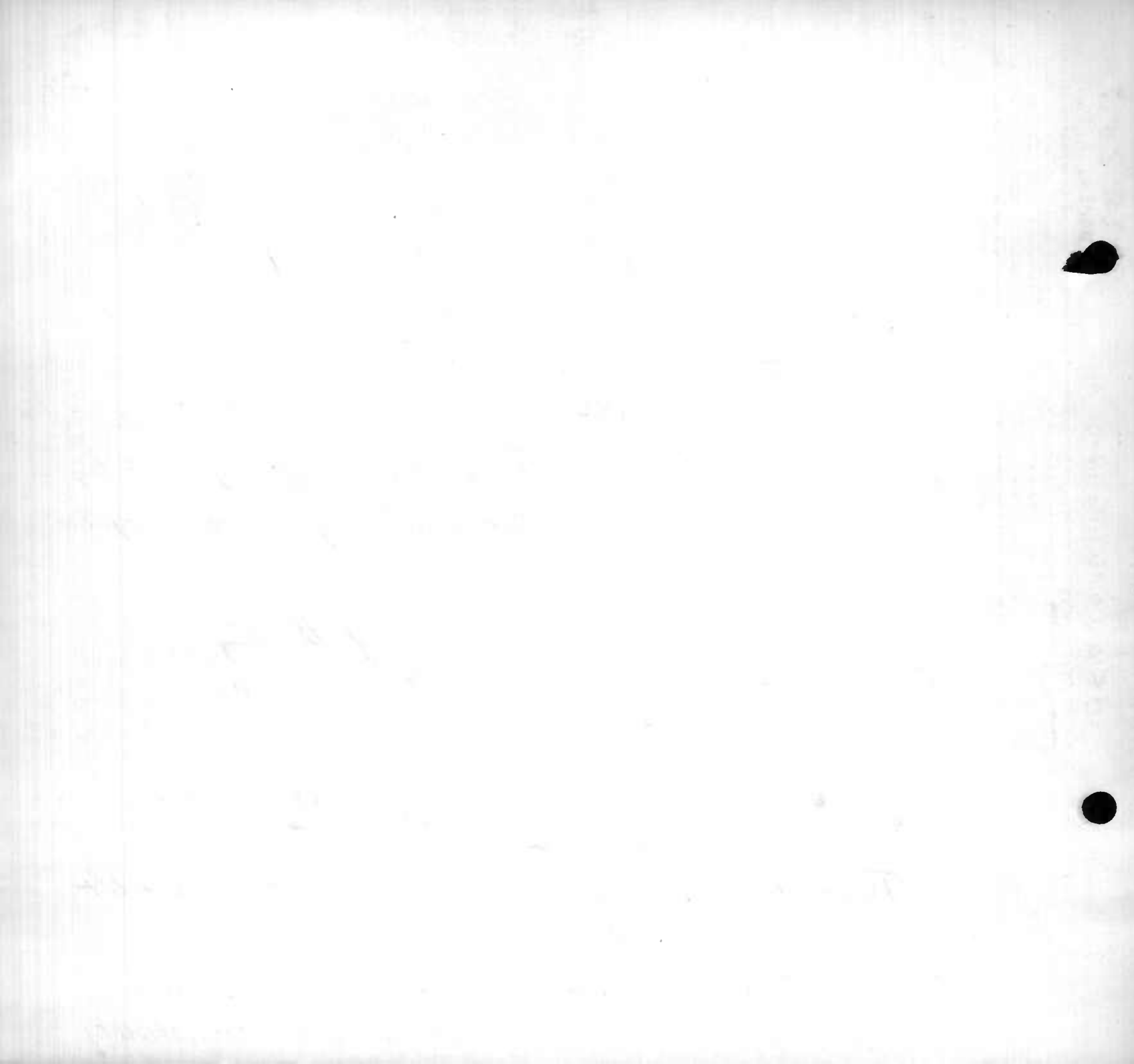
1009 5th Ave. New York, N.Y.

1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5420			
BIRTH NO. 67 5420													
M.E. CASE NO.													
1. NAME OF DECEASED (Type or Print) <u>Sara E. Cooper</u>					2. DATE AND HOUR OF DEATH <u>6-2-67</u> <u>3:10 A.M.</u>								
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>								
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>								
D. STREET ADDRESS (If rural, give location) <u>3706 N. CHARLES STREET 21218</u>													
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>2-3-03</u>		9. AGE (In years last birthday) <u>64</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Service</u>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>Lutherville, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>EMMANUEL WITTERMAN</u>					14. MOTHER'S MAIDEN NAME <u>ELIZABETH BOAL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>					16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>John W. Hessian - Po 6892 - Towson 4, Md</u>					ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>3-27-21-16-3 X</u>					CAUSE OF DEATH (A) <u>Respiratory insufficiency</u> (B) <u>Chronic Lung Disease</u> (C) <u>4 days</u> <u>years</u>					INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>II</u>					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Carcinoma of the Lung.</u>								
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <u>5-30</u> <u>19 67</u> to <u>6-2</u> <u>19 67</u> , that (we) last saw the deceased alive on <u>6-2</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.													
23A. SIGNATURE <u>Richard L. Bishop</u> M.D.										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-2-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>RICHARD L. BISHOP</u>					23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>								
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>6-5-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md -</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 5 1967</u>			25B. NAME OF REGISTRAR <u>Deane E. Fennell</u>			25C. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>			ADDRESS <u>4600 Liberty</u>				



1
H-635

67 5421

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5421

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDGAR E. HARTNER

2. DATE AND HOUR PRONOUNCED DEAD

6-2-67

9:35 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 BALTIMORE CITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3320 Hudson Street 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 18, 1931

9. AGE (in years
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Electrician

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Hartner

14. MOTHER'S MAIDEN NAME

Jenny Cavander

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korean

16. SOCIAL
SECURITY NO.

216 28 3740

17. INFORMANT

Gloria Hartner Same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3320 Hudson Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
6 1 '67 7:30 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self during altercation with wife

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-2-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6/6/67

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Md.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

JUN 6 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Luzdzinski Funeral Home 1407 Eastern Ave.

ADDRESS

Sept. 18, 1937

Parties

Ballington, W.

Constitution

Electrolan

Henry Cavender

Charles Barker

Glenn Barker, Jane

206 28 3740

Kosman

Yes

Ballington National Cemetery, Ballington, W.

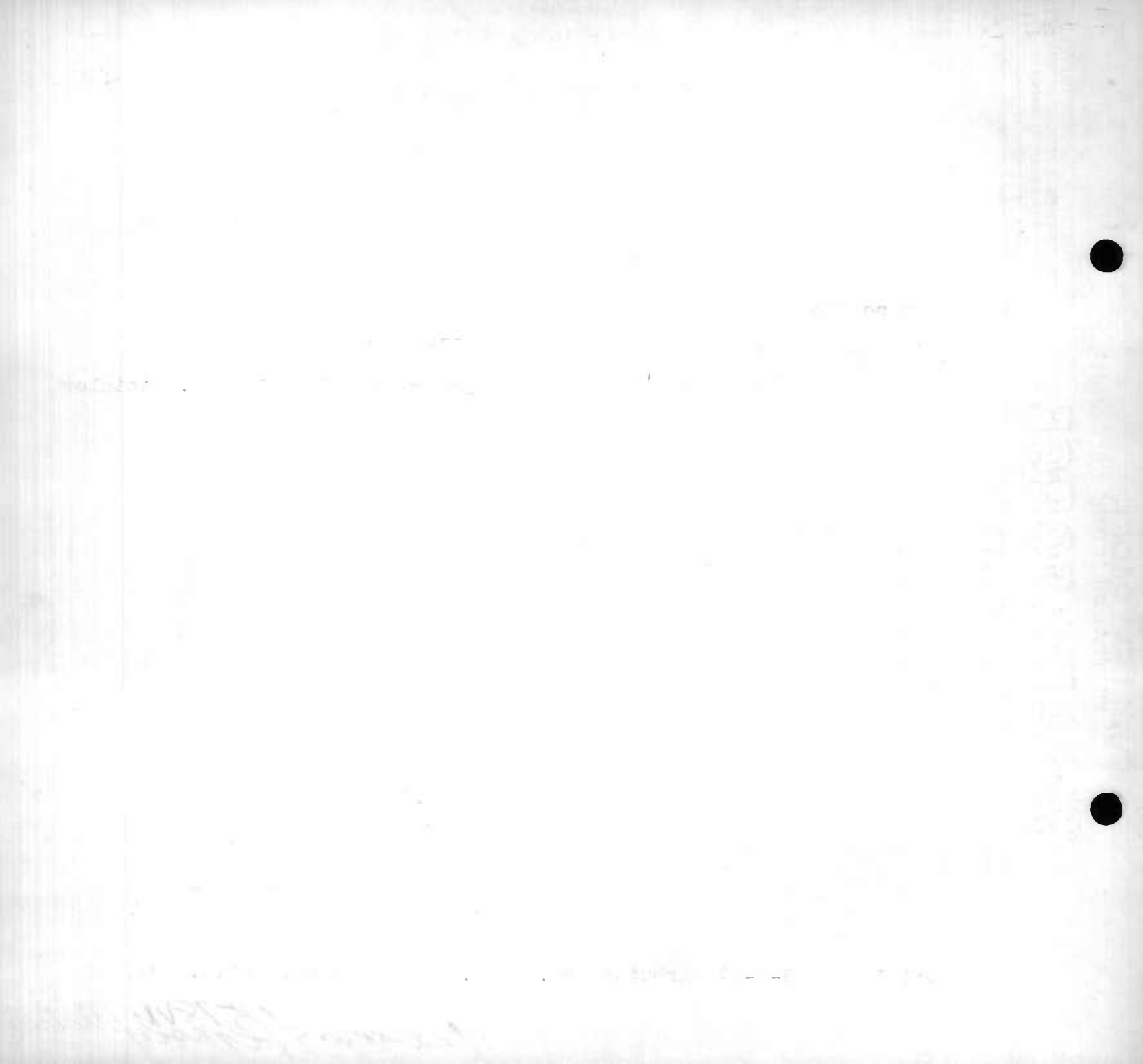
21613

Barial

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5422				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5422	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) VIOLA S. GRANDISON				2. DATE AND HOUR OF DEATH 6-3-67 4:42 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21216 D. STREET ADDRESS (If rural, give location) 1722 N. BENTALOW ST.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEP.	8. DATE OF BIRTH 4-2-02	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME LEM BROOKMAN				14. MOTHER'S MAIDEN NAME Ella Thomas			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr Leroy Grandison 1722 N. Bentalow		
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Diabetic Acidosis				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUNE 2 19 67 to JUNE 3 19 67 , that (I) (we) lost saw the deceased alive on JUNE 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A.S. de Perio				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-3-67	
23C. PHYSICIAN'S NAME (Type) Adolfo G. DE PERIO				23D. ADDRESS Bon Secours Hosp.			
24A. BURIAL CREMATION, REMAINS (Specify) Burial		24B. DATE 6-7-67		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park.		24D. LOCATION (City, town, or county) (State) Abbutus, Balto, Co., Md	
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967		25B. NAME OF REGISTRAR R. G. E. Taylor		25C. FUNERAL DIRECTOR Edward A. Hensley		25D. ADDRESS 1578 V. Biddle	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5423		67 5423			
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Riemann, William			2. DATE AND HOUR OF DEATH 6 4-67 3:P.M. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN Rural Baltimore D. STREET ADDRESS (If rural, give location) Box 111, Rt 5 Ridge Road Balto 7, Md.		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital Caton & Wilkens Ave.					
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH 5-16-86	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10B. KIND OF BUSINESS OR INDUSTRY A & P Tea Company	11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henry Reimann			14. MOTHER'S MAIDEN NAME Marie Markgraf		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-07-6823	17. INFORMANT ADDRESS Mrs Henry Reimann, Box 111, Rt 5, Balto 7, Md.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION - PROBABLE PNEUMONIA - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John J. Cabrera - M.D.			23B. DATE SIGNED 6/4/67		23C. PHYSICIAN'S NAME (Type) John J. Cabrera - M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/7/67		24C. NAME OF CEMETERY or CREMATORY Wards Chapel Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 8728 Liberty Road Randallstown Md	
24D. LOCATION (City, town or county) Balto Co.		24E. LOCATION (State) Md.			

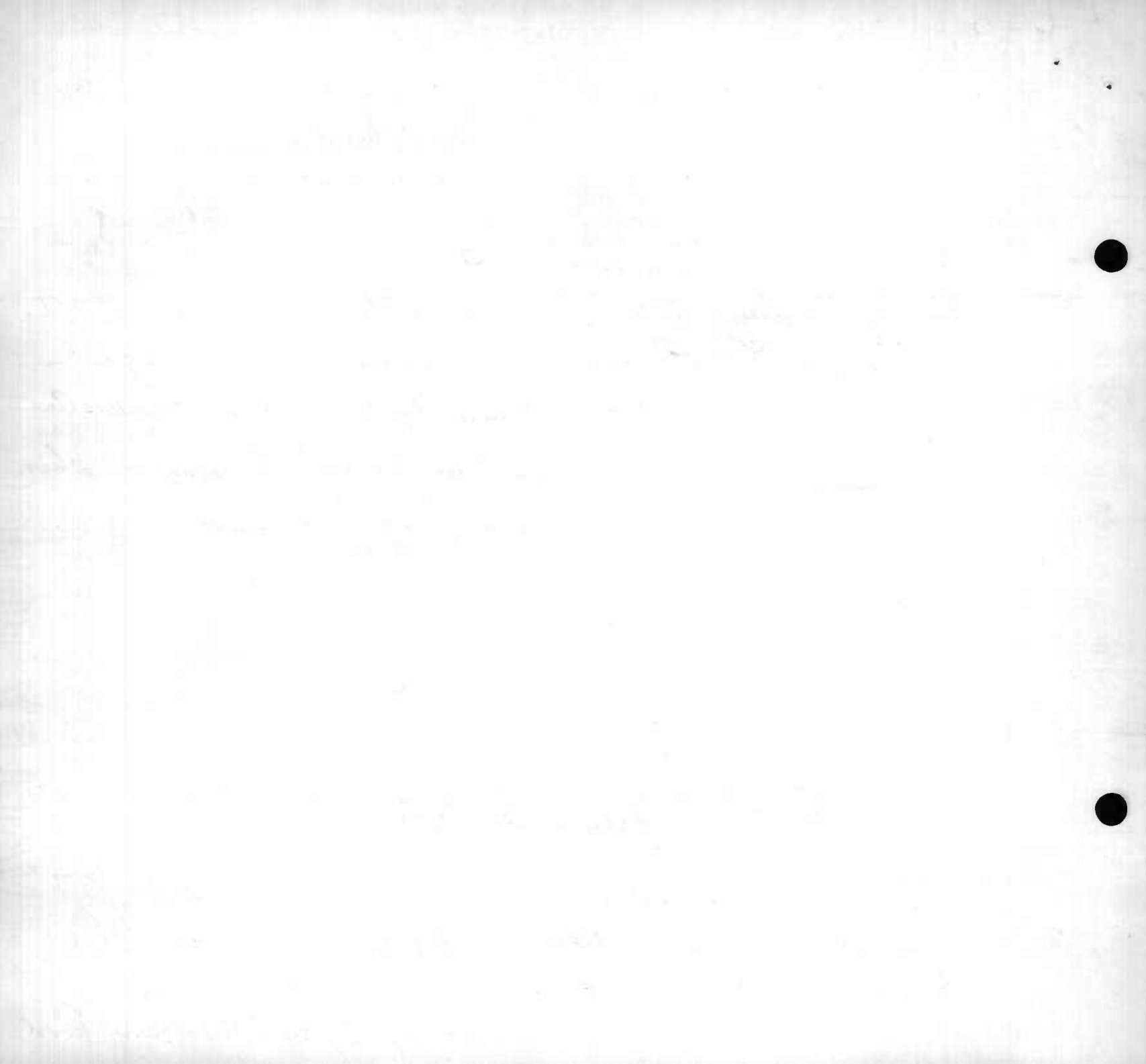
[Handwritten signature]

[Faint handwritten text]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5424	
BIRTH NO. 67 5424		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Frock, George</i>		2. DATE AND HOUR OF DEATH <i>6/4/67</i> <i>6:00 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>6311 Pearce Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>5/3/29</i>	9. AGE (In years lost birthday) <i>38</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Steamfitter Steamfitting</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		13. FATHER'S NAME <i>George F. Frock</i>		14. MOTHER'S MAIDEN NAME <i>Louisa B. Wenzel</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-09-3116</i>		17. INFORMANT <i>Mrs. Agalia H. Frock</i> ADDRESS <i>6311 Pearce Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.01</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Cardiac Arrest - Pulmonary Edema</i> DUE TO (B) <i>Arteriosclerotic heart disease</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 4</i> 19 <i>67</i> to <i>June 4</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>June 4</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ernest H. Henselberg</i> M.D.				23B. DATE SIGNED <i>6/4/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ernest H. Henselberg</i>		23D. ADDRESS <i>Sinai Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-7-1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 6 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Loring Byers</i> ADDRESS <i>8728 Liberty Road</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5425				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5425	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Oscar Powell</u>				2. DATE AND HOUR OF DEATH <u>May 30 1967</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3700 Columbus Drive Baltimore</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY	
C. CITY OR TOWN <u>Baltimore</u>		(If outside city limits, write RURAL and give township)		D. STREET ADDRESS <u>3700 Columbus Drive</u>		B 21218	
5. SEX <u>Male</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 2-1910</u>	9. AGE (in years last birthday) <u>57</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel mill</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Powell</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Brown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Alvin Powell</u>		ADDRESS <u>Same</u>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Renal Failure</u>		CAUSE OF DEATH (A) DUE TO <u>Chronic nephrolithiasis and pyelonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Post left nephrectomy for Carcinoma</u>		(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 1964</u> 19 <u>67</u> to <u>May</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 25</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edward W. Campbell, Jr. M.D.</u>				23B. DATE SIGNED <u>June 3, 1967</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. <u>University Hospital Balt Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-3-67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Carmel Cent</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 6 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey</u>		25C. FUNERAL DIRECTOR <u>Elroy Wilcox</u>		ADDRESS <u>1000 Brunty Ln</u>	



1
E-363

67 5426

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5426

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEONARD EDWARDS

2. DATE AND HOUR PRONOUNCED DEAD

6-2-67

6:20 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 SOUTH BALTIMORE GENERAL HOSPITAL-DOA
99

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3211 Hawkins Point Road 21226

5. SEX

Male

6. RACE

Colored

7. ☒ MARRIED ☐ NEVER MARRIED
☐ WIDOWED, ☐ DIVORCED (specify)

8. DATE OF BIRTH

March 26 1912

9. AGE (In years last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cathonia, VA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Edwards

14. MOTHER'S MAIDEN NAME

Mary Allie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

16. SOCIAL SECURITY NO.

Mary Edwards

ADDRESS

Source

18. 443X I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) DUE TO

Hypertensive cardiovascular disease

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-2-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

6-7-67

23C. NAME of CEMETERY or CREMATORY

Balto Mt Cem

23D. LOCATION (City, town, or county) (State)

Balto Md

2120

24A. DATE REC'D BY HEALTH DEPT.

JUN 6 1967

24B. NAME OF REGISTRAR

Robert E. Sanku

24C. FUNERAL DIRECTOR

Shayou Wilson / 000 Brianthyle

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
 (If not in hospital or institution, give street address or location)
 31
 Baltimore City Hospitals
 4940 Eastern Avenue
 Baltimore, Maryland 21224
 7-18-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 A. STATE Maryland B. COUNTY Baltimore
 C. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDALK RURAL 53-00
 D. STREET ADDRESS (If rural, give location) 225 Pinewood Road 21222

5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED 8. DATE OF BIRTH 4-21-1907 9. AGE (In years last birthday) 60 10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER 10B. KIND OF BUSINESS OR INDUSTRY HOME IMPROVEMENT 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME John 14. MOTHER'S MAIDEN NAME Mary

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 1926 16. SOCIAL SECURITY NO. 229-05-6956 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224

18. CAUSE OF DEATH
 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
 ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
 (A) Massive ~~bowel~~ Intestinal infarction
 (B) DUE TO
 (C) DUE TO
 INTERVAL BETWEEN ONSET AND DEATH 3 days

II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 6/2/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Abdomen 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Not While At Work Work At Work 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/1/67 to 6/3/67 that (I) (we) last saw the deceased alive on 6/3/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE 23B. DATE SIGNED 6/3/67

23C. PHYSICIAN'S NAME (Type) PABLO TREFOGGI M.D. 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 6/6/1967 24C. NAME OF CEMETERY OR CREMATORY OAK LAWN 24D. LOCATION BALTIMORE CO., MARYLAND

25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967 25B. NAME OF REGISTRAR W. BROOKS BRADLEY, DUNDALK, MD.

Baltimore City Hospital Records

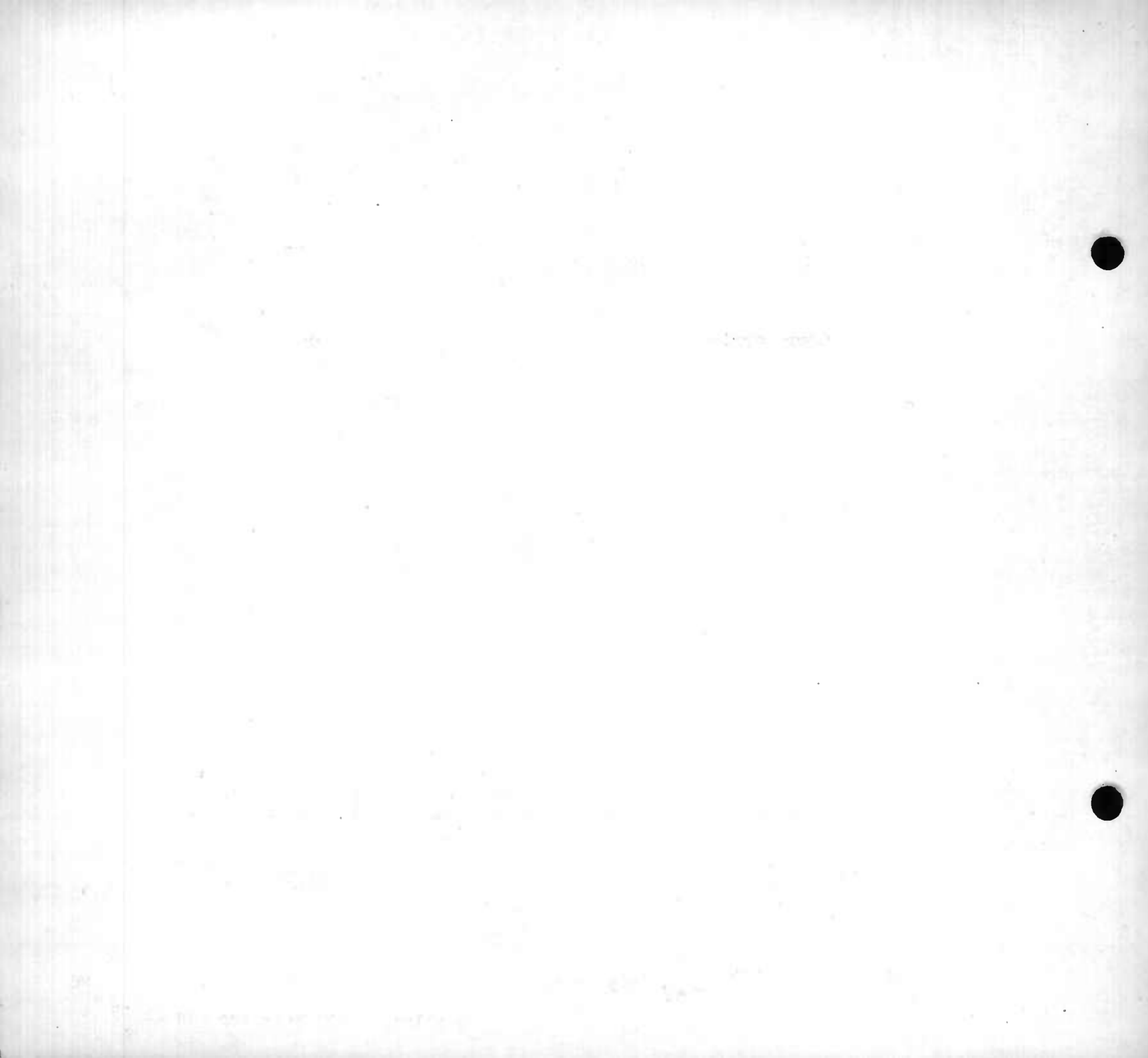
7-18-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5428				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5428	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				CARRICK, HOWARD A.		June 2, 1967 1:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Md.		B. COUNTY	
36 Franklin Square Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 21226 25-05	
D. STREET ADDRESS (If rural, give location)				4123 Graham Court		GRAHAM	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
M	White	married	9/24/44	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				Md		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Arthur Carrick				Emma Hunter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Family		Same	
18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Pneumonia (B) C.V.D. (C) A.S.C.V.D.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 1, 1967 to June 2, 1967, that (I) (we) last saw the deceased alive on June 2, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sung Bae Cha				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 2, 1967	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/6/67		Holy Cross		AA Co Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 6 1967		Robert E. G. G. G.		McQuilly F H		237 Patapsco Ave 21225	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

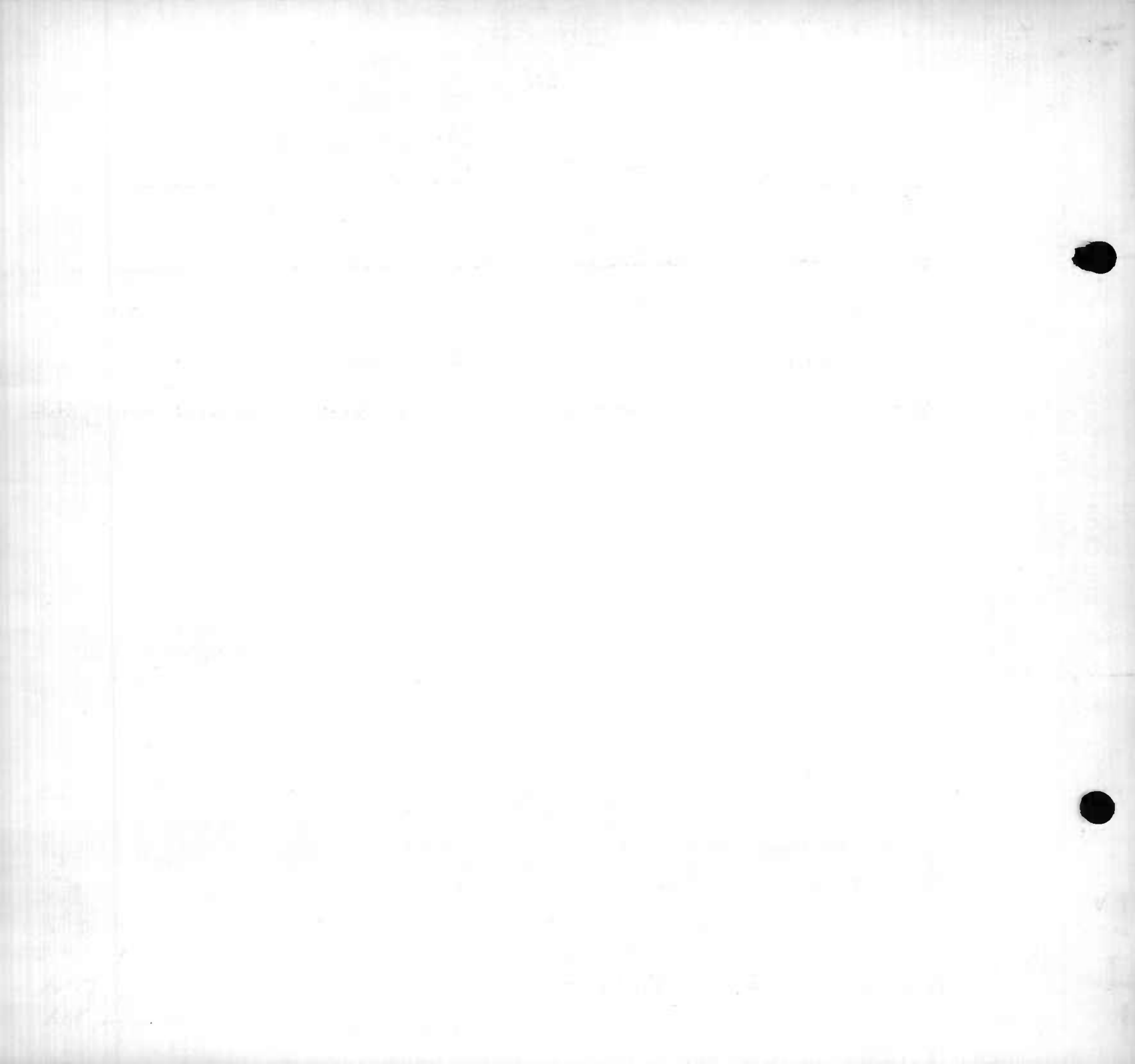
BIRTH NO. 67 5429		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5429	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) <i>Dippery, Charles T</i>		2. DATE AND HOUR OF DEATH <i>6-2-67</i> <i>10</i> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>ANNE ARUNDEL Co.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i> <i>33</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>ANNAPOLIS</i> <i>52-10</i>			
		D. STREET ADDRESS (If rural, give location) <i>700 AMERICANA AVENUE</i>			
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>6-8-08</i>	9. AGE (In years lost birthday) <i>58</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Personnel Social Security Ad.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SA</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
13. FATHER'S NAME <i>ARTHUR S. DIPPERY</i>		14. MOTHER'S MAIDEN NAME <i>ANNA C Koll</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Reuth Dippery</i> ADDRESS <i>above</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Renal Failure</i>		CAUSE OF DEATH (A) DUE TO <i>Acute Renal Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Gram @ sepsis, Prolonged vasopressor Rx. 9 days</i>		(B) DUE TO <i>Cholecystectomy Upper GI hemorrhage, Pancreatitis, Thrombocytopenia</i>		(C) <i>3 wks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>5-10-67</i> <i>5-25-67</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cholelithiasis duct structure - upper GI bleeding</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>5-8</i> 19 <i>67</i> to <i>6-2</i> 19 <i>67</i> , that we (we) last saw the deceased alive on <i>6-2</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did not) view the body after death.					
23A. SIGNATURE <i>Arthur C. Burdett</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>6-2-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ARTHUR C. BURDETT</i>		23D. ADDRESS M.D. <i>JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/5/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge</i>	
24D. LOCATION (City, town, or county) (State) <i>Dorsey, Howard Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 6 1967</i>			
25B. NAME OF REGISTRAR <i>Robert S. Barranco</i>		25C. FUNERAL DIRECTOR <i>Robert S. Barranco</i> ADDRESS <i>Severna Park, Md</i>			

EST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <u>67 5430</u>	
BIRTH NO. <u>67 5430</u>						CERTIFICATE OF DEATH	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>JENNIE COPLON</u>				2. DATE AND HOUR OF DEATH <u>6-3-67 4:45 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
<u>HOUSE IN THE PINES - BELV AVE</u>		<u>90</u>		<u>MD</u>			
5. SEX <u>F</u>				6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SINGLE</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>FEB 7, 1892</u>		9. AGE (In years last birthday) <u>75</u>	
				11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SOLOMON</u>				14. MOTHER'S MAIDEN NAME <u>BERTHA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>244-72-3792</u>		17. INFORMANT <u>MR HARRY COPLON</u>		ADDRESS <u>P.O. Box 3098</u>	
18. <u>4-20-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>acute myocardial infarction</u> DUE TO (B) <u>arteriosclerosis, C.V.D.</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 11</u> 19 <u>67</u> to <u>June 3</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. A. Silver</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>6-3-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. A. SILVER</u>		23D. ADDRESS <u>6210 Park Heights Ave. Balto. Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/6/1967</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Friendship</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 6 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Sylvan S. Lewis & Son, Inc</u>		ADDRESS <u>Garrison, Md</u>	



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

2. DATE AND HOUR PRONOUNCED DEAD

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

421 N. GILMORE - Amb. Crew #4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

421 N. Gilmore Street

21223

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

SEPARATED

8. DATE OF BIRTH

12-11-1930

9. AGE (In years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

Keller M.I.I.

11. BIRTHPLACE (State or foreign country)

Dayton - OHIO

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

BERT PERKINS

14. MOTHER'S MAIDEN NAME

BERTHA

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

291-24-7018

17. INFORMANT

ADDRESS

RACHEL SMITH 421 N. Gilmore St

18.

416X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Rheumatic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-5-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-10-1967

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

JUN 6 1967

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Thos. J. R. Hays 638 N. Gilmore St

ADDRESS

WILLIAM FORMER

1844

1844

1844

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 5432					CERTIFICATE OF DEATH					Registered No. 67 5432				
1. NAME OF DECEASED (Type or Print) <i>Bessie Goldberg</i>										2. DATE AND HOUR OF DEATH <i>June 3rd 1967 5.50 A.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Sinai Hospital of Baltimore</i>										4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION <i>42</i>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
										D. STREET ADDRESS (If rural, give location) <i>6952 Glenheights Rd.</i>				
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Wid.</i>		8. DATE OF BIRTH 11/11/1911		9. AGE (In years last birthday) <i>68</i>		If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>				11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>? STEIN</i>						14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>215-03-1628</i>		17. INFORMANT ADDRESS <i>MRS. HETLEN HOFFMAN, SAXONY COURT (EDEN ROC)</i>								
18. <i>42011 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Acute Pulmonary edema</i> DUE TO										INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Coronary Insufficiency</i> DUE TO <i>ASCVD</i>										<i>Unknown</i> <i>Unknown</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <i>May 30th 1967</i> to <i>June 3rd 1967</i> , that (I) (we) last saw the deceased alive on <i>June 3rd 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
23A. SIGNATURE <i>William Cieplinski</i>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>6/3/67</i>				
23C. PHYSICIAN'S NAME (Type) <i>William Cieplinski</i>								23D. ADDRESS <i>Sinai Hospital of Baltimore</i>						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>				24B. DATE <i>6/4/67</i>		24C. NAME of CEMETERY or CREMATORY <i>RUDOMER VEREIN</i>			24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MARYLAND</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 6 1967</i>				25B. NAME OF REGISTRAR <i>Q. J. B. Taylor</i>				25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</i>						

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5433				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5433	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				RHEA ANDUR		JUNE 2, 1967 3:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 4308 PIMLICO ROAD				A. STATE MARYLAND			
(If not in hospital or institution, give street address or location)				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE		13-13	
				D. STREET ADDRESS (If rural, give location)			
				4308 PIMLICO ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
FEMALE	WHITE	WIDOW		71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE			AT HOME		RUSSIA		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
MEYER LEVINSON				ANNA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO			NO		MRS. CAROLYN GREENBERG, 4308 PIMLICO ROAD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4201 I				Coronary Occlusion		Immediate	
ANTECEDENT CAUSES				(B) DUE TO		Arteriosclerotic cardiac	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO		vascular disease 6 yrs.	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12-8 1961 to 6-2 1967, that (I) (we) lost saw the deceased alive on 5-30 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Irvin Sauber						6-3-67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. IRVIN SAUBER				6905 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		6/4/67		TIFERETH ISRAEL		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 6 1967		Robert E. Levinson		SOL LEVINSON & BROS. INC.		6010 REIST., RD.	

For the purpose of
the present investigation
the following data were
obtained from the
records of the
Department of the
Interior, Bureau of
Land Management,
Washington, D. C.

2-30-21
11-1-21

11-1-21

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5434	
CERTIFICATE OF DEATH					
BIRTH NO. 67 5434		M.E. CASE NO. F.			
1. NAME OF DECEASED (Type or Print) CHASE ISAACS		2. DATE AND HOUR OF DEATH 6-2-67 10:35 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. OF BALTO.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTO, MD. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5702 PALMER AVE.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 8/15/88	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-34-4681		17. INFORMANT MR. LUCIAN B. ISAACS, 3932 SETONHURST ROAD	
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHOLESTEROL II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
		(B) DUE TO CHOLESTEROL		10 years	
		(C) DUE TO Diabetes Mellitus		10 years	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION 0			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/1 19 46 to 6/2 19 67 , that (I) (we) last saw the deceased alive on 6/2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Israel Zinberg		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/2/67	
23C. PHYSICIAN'S NAME (Type) DR. ISRAEL ZINBERG		23D. ADDRESS 4000 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/4/67		24C. NAME OF CEMETERY or CREMATORY WORKMEN CIRCLE	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967			
25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR SEBASTIAN & BROS. INC., 6010 REISTERSTOWN			

MR. C. E. TAYLOR

SINCE 1904 OF DATE

F M

1904-1905

AD-1000000

2107 1000000

2107 1000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5435		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5435	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MR. THOMAS HEALEY			2. DATE AND HOUR OF DEATH 3:20 a.m. June 4, 1967		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE Co., Md. B. COUNTY BALTIMORE Co., Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk Maryland 53-00 D. STREET ADDRESS (If rural, give location) BALTIMORE Co., Md.		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH May 11, 1893	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Bearrow in Furness England	
13. FATHER'S NAME William Healey			14. MOTHER'S MAIDEN NAME Jackson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-67-1156		17. INFORMANT Mrs. Agnes Healey - same as deceased	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163X41260X Carcinoma of lower lobe of right lung			INTERVAL BETWEEN ONSET AND DEATH Jan-67-June 67		
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Antecedent Causes Discharge of cerebral vascular accident during surgery 5/8/67 uncontrolled diabetic			20. CAUSE OF DEATH (A) DUE TO the right lung (B) DUE TO Discharge of cerebral vascular accident during surgery 5/8/67 uncontrolled diabetic		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. the right lung					
19A. DATE OF OPERATION May 8, 1967		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the lower lobe of		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from April 12 19 67 to June 4 19 67 , that (I) (we) lost saw the deceased alive on June 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L. Rafael Miranda				23B. DATE SIGNED June 4, 1967	
23C. PHYSICIAN'S NAME (Type) DR. OTTO BRANTIGAN		23D. ADDRESS CH & H			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-7-67		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn	
24D. LOCATION (City, town, or county) (State) Baltimore County, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967			
25B. NAME OF REGISTRAR Robert E. Fady		25C. FUNERAL DIRECTOR W. Brooks Bradley, Dundalk, Md.			

1883

20th January

at 10.15 AM

at 10.15 AM

at 10.15 AM

May 11, 1883

May 11, 1883

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

at 10.15 AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

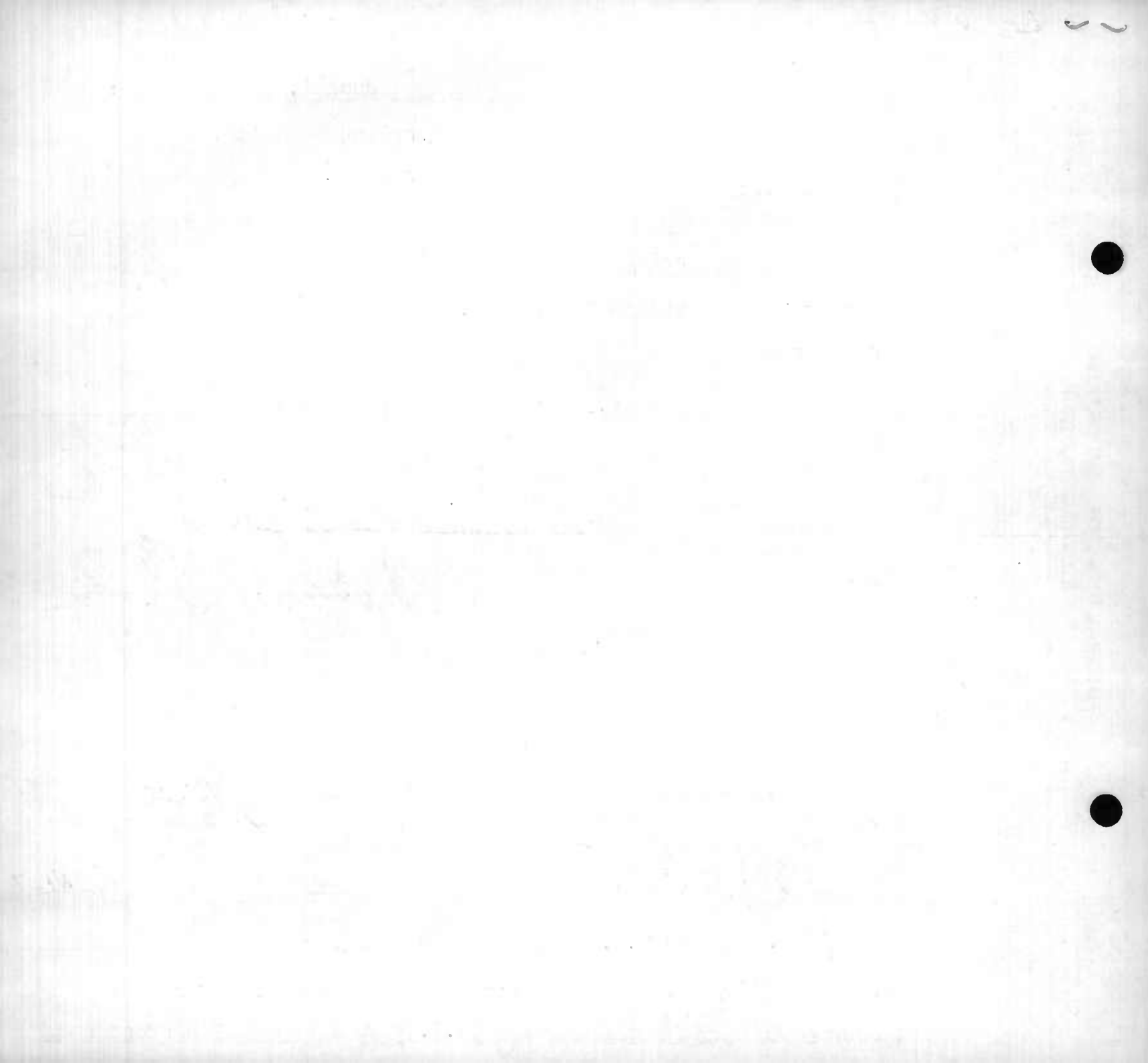
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5436	
BIRTH NO. 67 5436		CERTIFICATE OF DEATH		Registered No. 67 5436	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WILLIE DAVIS		2. DATE AND HOUR OF DEATH 6/3/67 8:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 8-05	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME & HOSPITAL 35		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 1807 N. BOND ST.	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8/7/99	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL LABORERS		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA, USA	
13. FATHER'S NAME ALLAN DAVIS		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 213-09-24260		17. INFORMANT Mary Davis 1807 N. Bond St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1-260 X		(A) Probable Acute DUE TO Myocardial Infarction - Hrs.		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Acute Pulmonary Edema - Hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pass. Diabetes Mellitus			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/3/67 19 to 6/3/67 19 that (I) (we) last saw the deceased alive on 6/3/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco Baltazar, Jr. M.D.				23B. DATE SIGNED 6/3/67	
23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR, JR. M.D.		23D. ADDRESS CHURCH HOME & HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 8/67		24C. NAME OF CEMETERY OR CREMATORY Balt. Natl Cem	
24D. LOCATION (City, town, or county) (State) 5501 Fredrick Ave		25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967			
25B. NAME OF REGISTRAR Dr. J. E. Johnson		25C. FUNERAL DIRECTOR Gerard T. Elickson 129 N. Caroline St			

UNKNOWN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

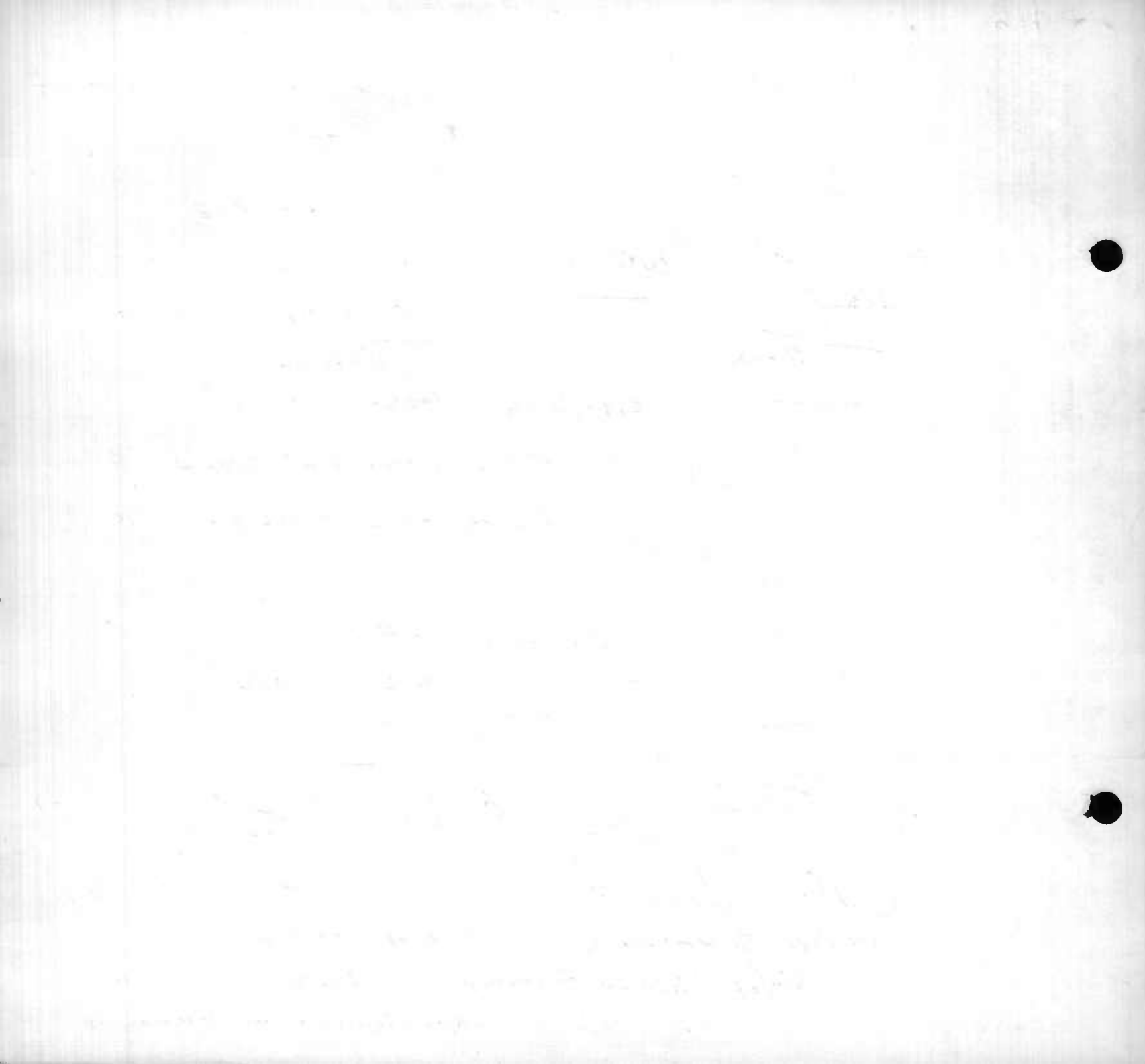
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5437	
CERTIFICATE OF DEATH					
BIRTH NO. 67 5437		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) ALDYSIUS F LORENZ			2. DATE AND HOUR OF DEATH June 1, 1967 9:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Balto City Hosp.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Parkville D. STREET ADDRESS (If rural, give location) 53-00 2722 Glendale road		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Sept 1 1900	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10B. KIND OF BUSINESS OR INDUSTRY Davidson Chem.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Conrad Lorenz			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 212-22-1682		17. INFORMANT Family Records
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (1) - Arterio-sclerotic heart disease - Angina pectoris (2) - Hypertension CVD (3) - Cerebral arteriosclerosis old aneurysm of aorta gangrene of aorta			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 17 19 60 to June 1 19 67 , that (I) (we) last saw the deceased alive on 5/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Donald W. Mintzer			23B. DATE SIGNED June 5 1967		
23C. PHYSICIAN'S NAME (Type) Donald W. Mintzer M.D.			23D. ADDRESS 3009 Evergreen avenue		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67		24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery	
24D. LOCATION Baltimore, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR J. C. EVANS & SON	
				ADDRESS 8802 Harford road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>67 5438</u>	
BIRTH NO. <u>67 5438</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ALBERT HALPERT</u>		2. DATE AND HOUR OF DEATH <u>6-1-67</u> <u>6:45</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI</u>		A. STATE <u>MD.</u> B. COUNTY <u>BALT.</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALT.</u>			
		D. STREET ADDRESS (If rural, give location) <u>2311 ANOKA AVE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>11-15-01</u>	9. AGE (In years lost birthday) <u>65</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Balto. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frank</u>			14. MOTHER'S MAIDEN NAME <u>REBECCA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-05-0717A</u>	17. INFORMANT <u>HOSP. CHART.</u>		ADDRESS
18. <u>165X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>SUPERIOR VENA CAVA SYNDROME ?</u> DUE TO (B) <u>METASTATIC CA OF LUNG</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 YR</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic CHF.</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-31</u> 19 <u>67</u> to <u>6-1</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-1-67</u> 19 <u>67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alvin Schachter</u>				23B. DATE SIGNED <u>6-1-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALVIN SCHACHTER</u>				23D. ADDRESS M.D. <u>SINAI HOSP.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/4/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>	
24D. LOCATION <u>BALTO.</u>		(City, town, or county)		(State) <u>MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 6 1967</u>		25B. NAME OF REGISTRAR <u>Alvin Schachter</u>		25C. FUNERAL DIRECTOR <u>SINAI HOSP. & SON, INC. GARRISON, MD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5439	
BIRTH NO. 67 5439		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Edith Lipsitz</i>			2. DATE AND HOUR OF DEATH <i>June 3rd 1967 5.45 A.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Sinai Hospital of Baltimore</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>42</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto. Co.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 53-00</i> D. STREET ADDRESS (If rural, give location) <i>6619 Dalton Dr.</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Wid.</i>	8. DATE OF BIRTH <i>10/22/95</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md. TENN.</i>	
13. FATHER'S NAME <i>Not Known</i>			14. MOTHER'S MAIDEN NAME <i>Not Known</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. HERBERT WAGNER - 6619 DALTON DRIVE</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Anasarca</i> DUE TO (B) <i>Congestive Heart Failure</i> DUE TO (C) <i>A S C V D</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i> <i>Unknown</i> <i>Unknown</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>			<i>Unknown</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 17th 1967</i> to <i>June 3rd 1967</i> , that (I) (we) lost saw the deceased alive on <i>June 3rd 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William Cieplinski</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>6/3/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>William Cieplinski</i>		23D. ADDRESS M.D. <i>Sinai Hospital of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/4/67</i>		24C. NAME of CEMETERY or CREMATORY <i>B'nai ISRAEL Cem.</i>	
24D. LOCATION <i>BALTO MD</i>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 6 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Finkelman</i>		25C. FUNERAL DIRECTOR <i>Shalom S. Lewis + Son Inc - GARRISON MD</i>	
ADDRESS					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 5440					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No. 67 5440					
1. NAME OF DECEASED (Type or Print) HERBERT S. SILVERMAN					2. DATE AND HOUR OF DEATH JUNE 4, 1967 10:30 A M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6200 BILTMORE AVE					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
					D. STREET ADDRESS (If rural, give location) 6200 BILTMORE AVE					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH Dec 29, 1904	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) office manager				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Michael					14. MOTHER'S MAIDEN NAME Sophie					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-05-8978		17. INFORMANT wife		ADDRESS Same		
18. 7/17 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Phemache Heart disease acute myeloid					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH over 2 yrs					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 1960 to June 4 1967 , that (I) (we) last saw the deceased alive on June 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Michael B. Kunkin					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/5/67			
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/5/67		24C. NAME of CEMETERY or CREMATORY BALTO HEBREW			24D. LOCATION (City, town, or county) (State) REISTERSTOWN MD			
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967			25B. NAME OF REGISTRAR Dr. E. E. Fink			25C. FUNERAL DIRECTOR John K. Lewis & Son Inc			ADDRESS the Garrison, Md	

1941 10 10

1941 10 10

1941 10 10

1941 10 10

1941 10 10

1941 10 10

1941 10 10

1941 10 10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 67 5441	
BIRTH NO. 67 5441		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>MARTHA MARGARET Wheeler</i>		2. DATE AND HOUR OF DEATH <i>6/1/67 12 midnite</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Charles Co.</i>			
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		8. DATE OF BIRTH <i>11-18-1905</i>	
13. FATHER'S NAME <i>Edward Smallwood</i>		14. MOTHER'S MAIDEN NAME <i>Mary Queen</i>		9. AGE (In years last birthday) <i>61</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>RECORDS: BCH 4940 Eastern Avenue 21224</i>	
18. <i>493X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Respiratory Insufficiency</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Pneumonia</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CVA's</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>3 months</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/29</i> 19 <i>67</i> to <i>6/1</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6/1</i> 19 <i>67</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Judith Hall</i>				23B. DATE SIGNED <i>6/1/67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Judith Hall</i>				23D. ADDRESS <i>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/6/1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Ghost Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 6 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Archart Funeral Home, Inc.</i>	
24D. LOCATION (City, town, or county) (State) <i>Issue, Maryland</i>		25D. ADDRESS <i>La Plata, Md.</i>		25E. ADDRESS <i>La Plata, Md.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5442					CERTIFICATE OF DEATH			Registered No. 67 5442	
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) STANLEY W. THOMPSON					6/2/67 5:30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles General Hospital					A. STATE MD B. COUNTY Baltimore Co				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 53-00				
5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married					D. STREET ADDRESS (If rural, give location) 863 Loalan Ave 21222				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Dept					11. BIRTHPLACE (State or foreign country) relax Md.				
10B. KIND OF BUSINESS OR INDUSTRY Balto. County					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ALTON Thompson					14. MOTHER'S MAIDEN NAME Queenie M. Moran				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Navy WWII					16. SOCIAL SECURITY NO. 219-12-6060				
17. INFORMANT North Charles General Hosp					ADDRESS				
18. 1992 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Metastatic Sarcoma				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 5-24 19 67 to 6-2 19 67 , that (I) (we) last saw the deceased alive on 6-2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Marceline Cruz					23B. DATE SIGNED 6/2/67				
23C. PHYSICIAN'S NAME (Type) Marceline Cruz					23D. ADDRESS North Charles General Hosp				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 6/6/67				
24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery					24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967					25B. NAME OF REGISTRAR John J. Duda				
25C. FUNERAL DIRECTOR John J. Duda					ADDRESS 7922 Wise Ave. Dundalk, Md.				

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5443		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5443	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Evelyn R. Alevato		2. DATE AND HOUR OF DEATH 6-4-67		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND North Charles General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk		D. STREET ADDRESS (If rural, give location) 6922 Sollers Point Road	
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital		E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		F. STREET ADDRESS (If rural, give location) 6922 Sollers Point Road	
5. SEX Female	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Dec. 15, 1926	9. AGE (In years last birthday) 40 yrs.	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10B. KIND OF BUSINESS OR INDUSTRY Topps		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Harry J. Reinhold		14. MOTHER'S MAIDEN NAME Edna May Moore	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-24-8523		17. INFORMANT CHART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) Cardiac arrest due to acute myocardial infarction		19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Essential hypertension		20. INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. MEDICAL CERTIFICATION	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1964 to June 4, 1967 , that (I) (we) last saw the deceased alive on June 4, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE ATAOLLAH GOLPIRA		23B. DATE SIGNED June 4, 1967	
23C. PHYSICIAN'S NAME (Type) ATAOLLAH GOLPIRA		23D. ADDRESS 1942 Cedar Lane, Baltimore, Md. 21222		23E. FUNERAL DIRECTOR John J. Buda	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/7/67		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 9 1967		25B. NAME OF REGISTRAR John J. Buda	
25C. FUNERAL DIRECTOR John J. Buda		25D. ADDRESS 7922 Wise Ave. Dundalk, Md.		25E. DATE OF DEATH June 4, 1967	

No

North Charles General Hospital
Chief

Sales Lady
Tops
Maryland
United States

Female Case, married
Dec. 15, 1944 40 yrs

North Charles General Hospital
6932 Solters Point Road

Mr. Dumbalk
6-4-41
21202

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 67 5444		Registered No. 67 5444	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) CAROLYN CARTWRIGHT			
2. DATE AND HOUR OF DEATH				6-2-67 7 50 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
48 Maryland General Hosp		Md Baltimore Co.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore - Sparrows Point 53-00	
D. STREET ADDRESS (If rural, give location)				1304 FORREST RD			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		White		MARRIED		3-31-03	
9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
64		Housewife				N. CAROLINA	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
USA				John JOHNSON			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Belle V. Daniels				No			
16. SOCIAL SECURITY NO.				17. (Informant) ADDRESS			
220-12-7497				(Husband) Sparrows Pt. Md. Graham R. Cartwright, 1304 Forrest Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
19. ANTECEDENT CAUSES				INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO Cardiac arrest 20 MIN			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Asystole 1 MIN			
II				(C) Myocardial infarction 48 hrs.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Coronary atherosclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
(Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6-1-67 19 to 6-2 1967, that (I) (we) last saw the deceased alive on 6-2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Timothy K Gray M.D.		6-2-67		TIMOTHY K GRAY M.D.		MARYLAND GENERAL HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6/5/67		Meadowridge Memorial Pk. Cem.		Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 6 1967		Robert E. Taylor, M.D.		John J. Duda		7922 Wise Ave. Dundalk, Md.	

100

100

100

100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5445	
BIRTH NO. 67 5445		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>McKietrick, Dena A.</i>		2. DATE AND HOUR OF DEATH <i>6/3/67 745 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>BALTO.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 BON SECOURS</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 21229 Md, 25-31</i>			
		D. STREET ADDRESS (If rural, give location) <i>515 COVENTRY Rd.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3-2-06</i>	9. AGE (If years lost birthday) <i>61</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DENTAL ASSISTANT</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>DENTISTRY</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>HARRY BELL</i>			
14. MOTHER'S MAIDEN NAME <i>BERNARDINE HUMMEL</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			
16. SOCIAL SECURITY NO. <i>215101564</i>		17. INFORMANT <i>MILBERT MCKIETRICK</i> ADDRESS <i>515 COVENTRY Rd</i>			
18. CAUSE OF DEATH <i>331X1</i>		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>cerebrovascular accident</i>		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Juny Kook Lee</i> M.D.				23B. DATE SIGNED <i>6-3-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>Juny Kook Lee</i> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/7/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>NEW CATHEDRAL cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. 21229 Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 6 1967</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>E. S. MacNabb</i> ADDRESS <i>301 Frederick Rd Balto 21228 Md</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5446	
BIRTH NO. 67 5446		M.E. CASE NO. 67 5446		1. NAME OF DECEASED (Type or Print) <u>Mc Cormick, Hubert R.</u>	
2. DATE AND HOUR OF DEATH <u>June 5, 1967 3:20 A.M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>		5. SEX <u>M</u> 6. RACE <u>White</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>902 S Carey ST</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Chemical Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Balti. Ind.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James J. McCormick</u>			
14. MOTHER'S MAIDEN NAME <u>Minnie Garrison</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>219-01-8755</u>		17. INFORMANT <u>Mrs. Mary Kline - 225 Otis Drive, Seneca, Md.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial infarction</u>		19. CAUSE OF DEATH (A) DUE TO <u>June 4, 1967</u> (B) DUE TO <u>June 5, 1967</u> (C) _____			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 4</u> 19 <u>67</u> to <u>June 5</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 5</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D.B. Ha</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6/5/67</u>	
23C. PHYSICIAN'S NAME (Type) _____		23D. ADDRESS <u>Franklin Square Hosp. Balt. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/8/67</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Balti. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 6 1967</u>			
25B. NAME OF REGISTRAR <u>W. B. E. Hadden</u>		25C. FUNERAL DIRECTOR <u>John E. Brown - Seneca, Ind. 901 Jackson St. Balt. Md.</u>			

88

12/2/8

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5447	
BIRTH NO. 67 5447		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Frederick O'Yh.		2. DATE AND HOUR OF DEATH 6/5/67 12 noon M.	
CERTIFICATE AMENDED					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore Md. B. COUNTY MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 1917 W. Pro H St. D. STREET ADDRESS (If rural, give location) 1917 W Pro H St.			
5. SEX M	6. RACE C-white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 8/2/91	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore - Md.	12. CITIZEN OF WHAT COUNTRY? US A
13. FATHER'S NAME George O'Yh			14. MOTHER'S MAIDEN NAME Henricha.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I		16. SOCIAL SECURITY NO. 213-05-3109		17. INFORMANT Mrs. Louis M. Dost, Cousin 4508 Dunland Rd.	
18. 610X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia		CAUSE OF DEATH (A) DUE TO Acute pyelonephritis 2 abscesses weeks (B) DUE TO Acute pyelonephritis 2 abscesses weeks (C) DUE TO Acute pyelonephritis 2 abscesses weeks		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 23 1967 to June 5 1967 that (I) (we) last saw the deceased alive on June 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.M. Ghiladi M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED June 5/67	
23C. PHYSICIAN'S NAME (Type) Abdolhamid Ghiladi M.D.				23D. ADDRESS Bon Secours.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/67		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.	

6/9/67 - Correction form from funeral director.

ABC.

Funeral Home
20. Lincoln St.
911-1-11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5448	
BIRTH NO. 67 5448		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Blunt, Margie Regina</i>		2. DATE AND HOUR OF DEATH <i>June 1, 1967 1:45 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>19-04</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>1607 W. Lombard St.</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>5/9/18</i>	9. AGE (In years last birthday) <i>49</i>	10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Howard co. Md.</i>	
13. FATHER'S NAME <i>late- Charles Bidinger</i>			14. MOTHER'S MAIDEN NAME <i>late- (unknown)</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mr. George Blunt 1607 W. Lombard St.</i>	
18. <i>581.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CIRRHOSIS OF LIVER from ?</i>		(A) DUE TO		(B) DUE TO <i>Hepatic Coma</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		INTERVAL BETWEEN ONSET AND DEATH <i>to May June 1, 1967</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 30</i> 19 <i>67</i> to <i>June 1</i> 19 <i>67</i> , that (I) (we) lost saw the deceased alive on <i>June 1</i> , 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sang Bae He,</i>				23B. DATE SIGNED <i>June 1, 1967</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>Franklin Square Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/5/1967</i>		24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 6 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Witzke F.D. 4101 Edmondson Ave.</i>	

...

... ..

...

...

...

...

...

...

...

...

...

...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5449	
BIRTH NO. 67 5449		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) BOWINKELMAN, ANNA		2. DATE AND HOUR OF DEATH JUNE 4 1967 4:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 23-03 D. STREET ADDRESS (If rural, give location) 1816 LIGHT ST.		
5. SEX F.	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 5-12-97	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor lady		10B. KIND OF BUSINESS OR INDUSTRY Linen thread co.	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME LOUIS BOWINKELMAN			14. MOTHER'S MAIDEN NAME SARAH KANE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 09 3634	17. INFORMANT ADDRESS (SISTER) MRS. RITA WALSH . 517 COVENTRY RD		
18. 153.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CA. Descending Colon (Terminal stage) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5-11-67 ~ 6-4-67
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5-16-67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fair		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) (HOME)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 11 1967 to JUNE 11 1967 , that (I) (we) last saw the deceased alive on JUNE 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chall Hi Lee				23B. DATE SIGNED JUNE 4. 67	
23C. PHYSICIAN'S NAME (Type) CHULL HI LEE			23D. ADDRESS M.D. FRANKLIN SQ. HOSP. BALTO. MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/7/67	24C. NAME OF CEMETERY or CREMATORY New Cathedral Com.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967		25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR ADDRESS Witzke F. D. - 4101 Edmondson Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5450	
BIRTH NO. 67 5450		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Richard L. Pierce		2. DATE AND HOUR OF DEATH June 1, 1967 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 5047 West Hills Rd.		A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 5047 West Hills Rd.			
5. SEX M	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH July 13, 1879	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-09-7417		17. INFORMANT Mrs. Edwin Lucas 234 Stonecroft	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 433, 11 DUE TO Cardiac arrhythmia Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Adam Stokes Syndrome Arteriosclerotic Myocardial Degeneration		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1967 to June 1967, that (I) (we) last saw the deceased alive on June 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William J. Bryson		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 6 1967	
23C. PHYSICIAN'S NAME (Type) William J. Bryson		23D. ADDRESS 4605 Edmondson Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 5, 1967		24C. NAME of CEMETERY or CREMATORY Western	
24D. LOCATION Baltimore Maryland		24E. FUNERAL DIRECTOR Witko Funeral Dir. 4101 Edmondson Ave.			
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Witko Funeral Dir. 4101 Edmondson Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5451					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 5451				
1. NAME OF DECEASED (Type or Print) MICULIAN, MARTHA					2. DATE AND HOUR OF DEATH 6-4-67 2:50A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL					A. STATE MARYLAND B. COUNTY BALTIMORE C.				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21228				
					D. STREET ADDRESS (If rural, give location) 5442 MASEFIELD ROAD				
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED MARRIED	8. DATE OF BIRTH 3-25-97	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ANTHONY HLINKA					14. MOTHER'S MAIDEN NAME ANNA KREMBASKI				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 119-22-1640A		17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVES. 21229				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 223X1 Brain Tumor (meningeal)					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 5-9-67			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Brain Tumor			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from APRIL 27 19 67 to JUNE 4 19 67, that (I) (we) last saw the deceased alive on JUNE 4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. SUAREZ					23B. DATE SIGNED 6/4/67			23C. PHYSICIAN'S NAME (Type) R. SUAREZ	
23D. ADDRESS CATON & WILKENS AVE. BALTIMORE MD					23E. FUNERAL DIRECTOR Harry Witzke				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE June 6 '67		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 6 1967			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Howard H. Co. Funeral of Ellicott City Md			

100:2

100:2

100:2

100:2

100:2

100:2

100:2

100:2

100:2

100:2

100:2

100:2

100:2

H-536

67 5452

BALTIMORE CITY HEALTH DEPARTMENT

67 5452

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James Henderson

2. DATE AND HOUR PRONOUNCED DEAD

June 4, 1967

2:35 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY X

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

446 Manse Ct.

5. SEX

M

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

July 2, 1901

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Sanders Henderson

14. MOTHER'S MAIDEN NAME

Mary Furgerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
213-01-890717. INFORMANT ADDRESS
Mary Henderson - 446 Manse Ct.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardio-vascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 4, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-8-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION (City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

JUN 6 1967

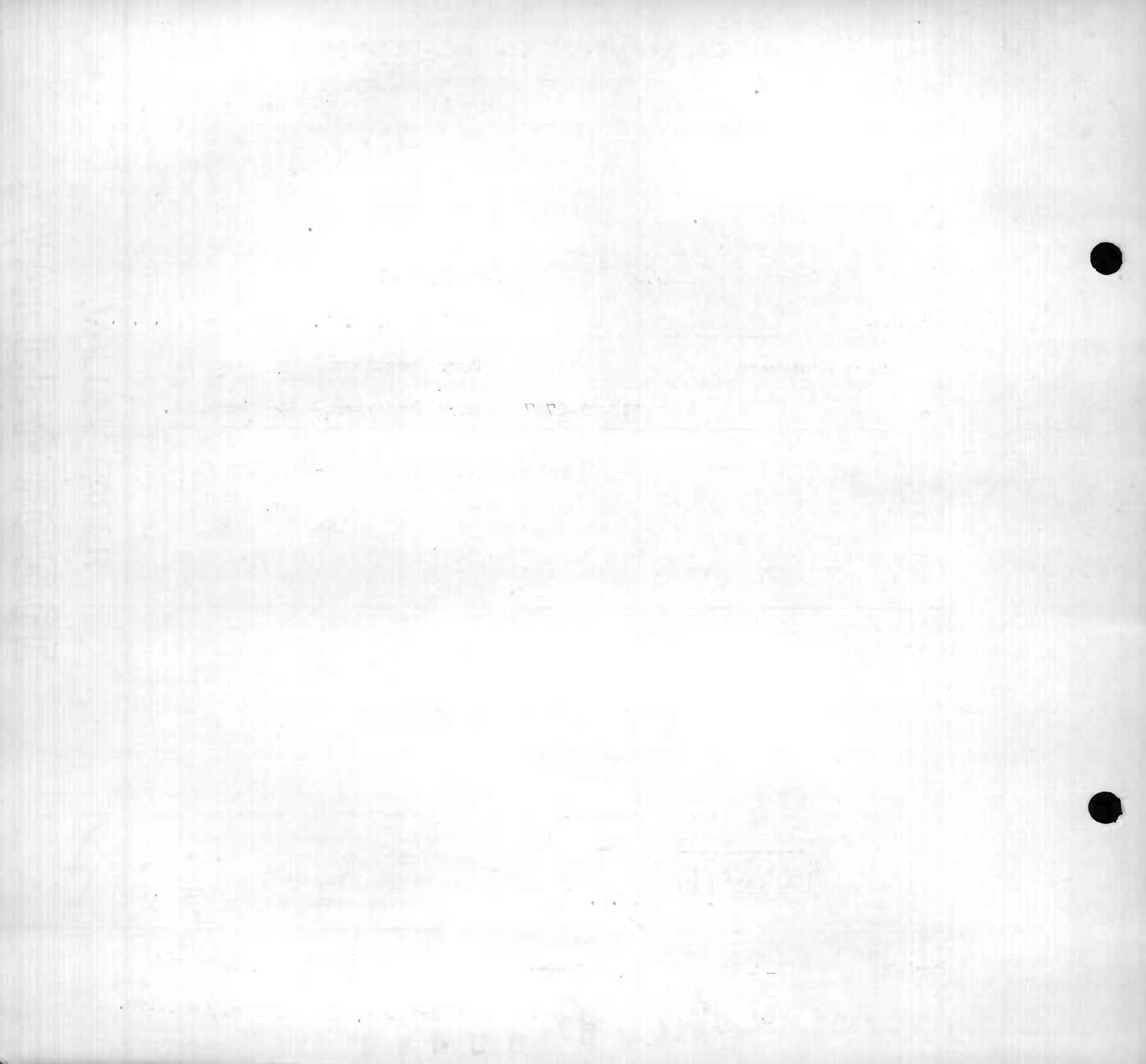
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <u>67 5453</u>	
BIRTH NO. <u>67 5453</u>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>TAYLOR, MOSES A.</u>		2. DATE AND HOUR OF DEATH <u>JUNE 2, 67</u> <u>6 P.</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>1224 McCulloh St.</u>			
5. SEX <u>Male</u>	6. RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>2-29-1904</u>	9. AGE (In years lost birthday) <u>63</u>	If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-3603</u>		17. INFORMANT <u>Barbara Alark - 3910 Dorchester Rd.</u>	
18. <u>581.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>ACUTE ANEMIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>BLEEDING ESOPHAGEAL VARICES</u> <u>CIRRHOSIS of LIVER</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 25</u> 19 <u>67</u> to <u>JUNE 2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JUNE 2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lizanzo</u>		M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6. 2. 67</u>	
23C. PHYSICIAN'S NAME (Type) <u>LIZARAZO</u>		23D. ADDRESS <u>PROVIDENT HOSPITAL.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-5-67</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D <u>JUNE 5 1967</u>		25B. NAME OF REGISTRAR <u>Charles R. Law</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law</u>	
				ADDRESS <u>802 Madison Ave.</u>	

THE HOTEL

GIARRAHOSE OF LIVER
BREEDING ESTABLISHMENT VARIOUS
ACUTE ANEMIA

MAY 26 1967

PROVIDENT HOSPITAL

LIZARRAZO



1870

1871

1872

1873

1874

1875

1876

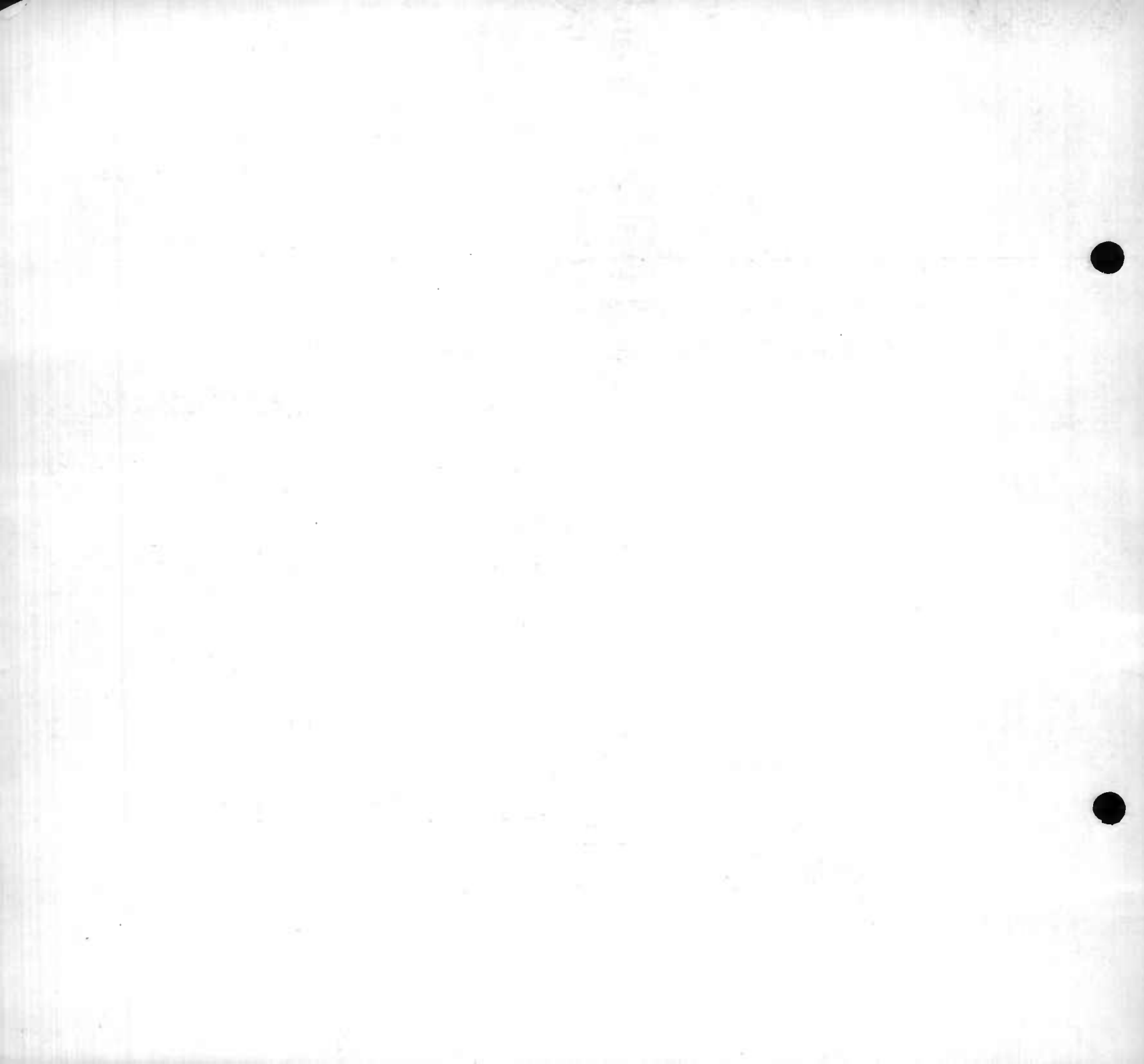
1877



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5455	
BIRTH NO. 67 5455		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Ida - A - Baier</i>		2. DATE AND HOUR OF DEATH <i>6-3-67</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Balto. City Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore - Maryland</i>			
		D. STREET ADDRESS (If rural, give location) <i>Balto 53-00</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>11-26-1906</i>	9. AGE (In years last birthday) <i>60</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>Robert White</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Benny</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John Baier - 6939 Eastbrook Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>443X1</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>CEREBRAL HEMORRHAGE</i> DUE TO (B) <i>HYPERTENSIVE CARDIO-</i> DUE TO (C) <i>VASCULAR DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6-3-67</i> <i>5-17-65</i>	
19. DATE OF OPERATION <i>NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NONE</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NONE</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NONE</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NONE</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>NONE</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> <i>NONE</i>		21F. HOW DID INJURY OCCUR? <i>NONE</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>5-17-65</i> 19 to <i>6-3-67</i> 19, that (I) (we) lost saw the deceased alive on <i>5-24-67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. A. Schimunek M.D.</i>				23B. DATE SIGNED <i>6-5-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. A. SCHIMUNEK M.D.</i>		23D. ADDRESS <i>842 S. EAST AVE BALTO. MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6/7/67</i>	24C. NAME OF CEMETERY or CREMATORY <i>Oakland Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 6 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Joseph N. Zimino</i>	
				ADDRESS <i>263 S. Conkling St</i>	



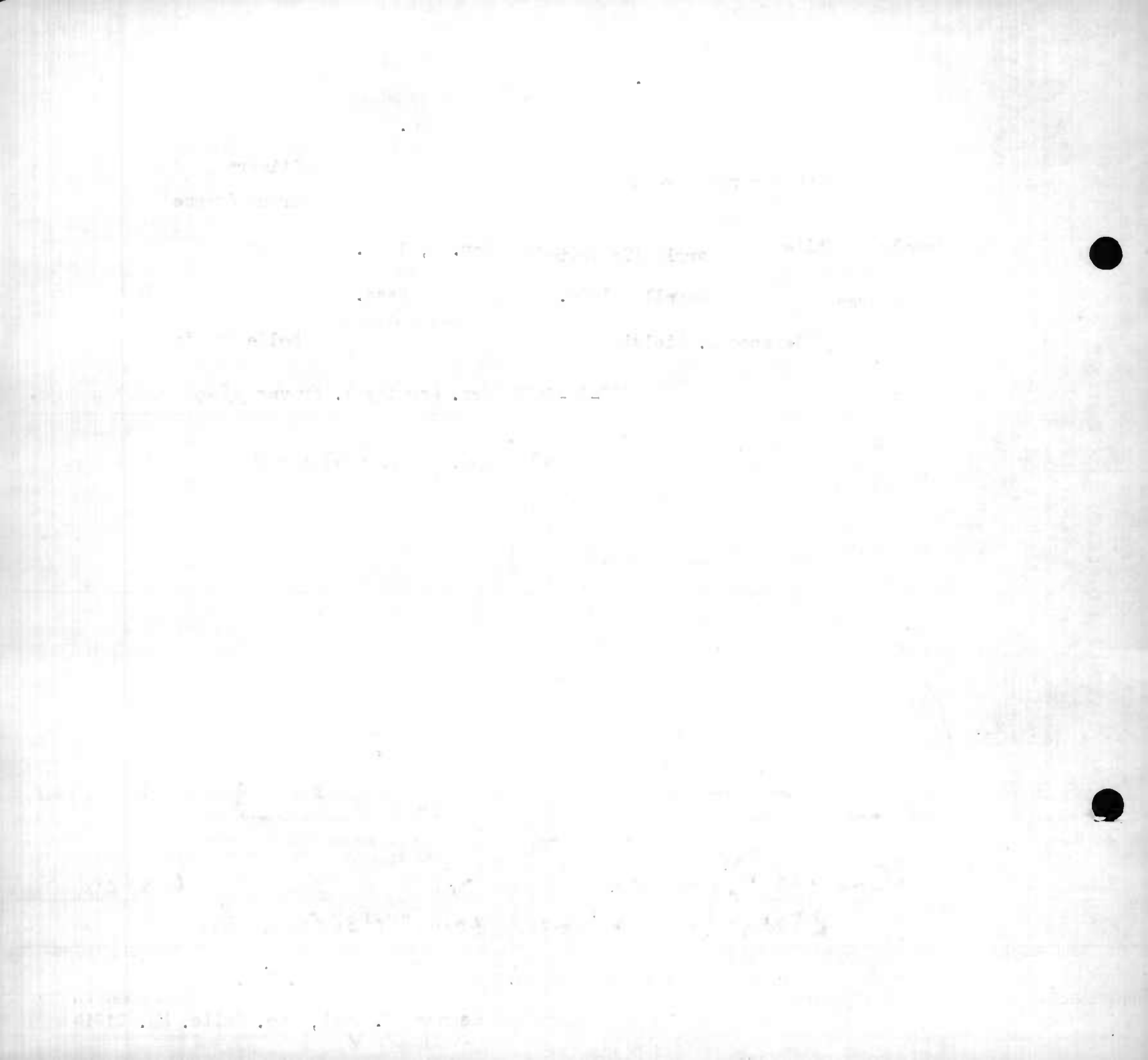
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5456	
BIRTH NO. 67 5456					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) John A. Naughton			2. DATE AND HOUR OF DEATH June 4, 1967. 9 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Harford Gardens Nursing Home			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1308 E. 35th. Street		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Aug. 2, 1886.	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bureau Receipts Recpts. Balto. City		10B. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Naughton			14. MOTHER'S MAIDEN NAME Bridget Kelly		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 214-40-2645		17. INFORMANT ADDRESS Mrs. Stephen Taormina, 5913 Winthrop Ave.	
18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Cerebral Thrombosis- Left DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 3 Weeks		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Broncho Pneumonia		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 4 1966. to June 3, 1967. that (I) (we) last saw the deceased alive on June 3 19 67. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sebastian Russo				23B. DATE SIGNED 6/4/67.	
23C. PHYSICIAN'S NAME (Type) Sebastian Russo		23D. ADDRESS 5017 Harford Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/7/67.		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.		25C. FUNERAL DIRECTOR ADDRESS Balto. Md. 2121	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

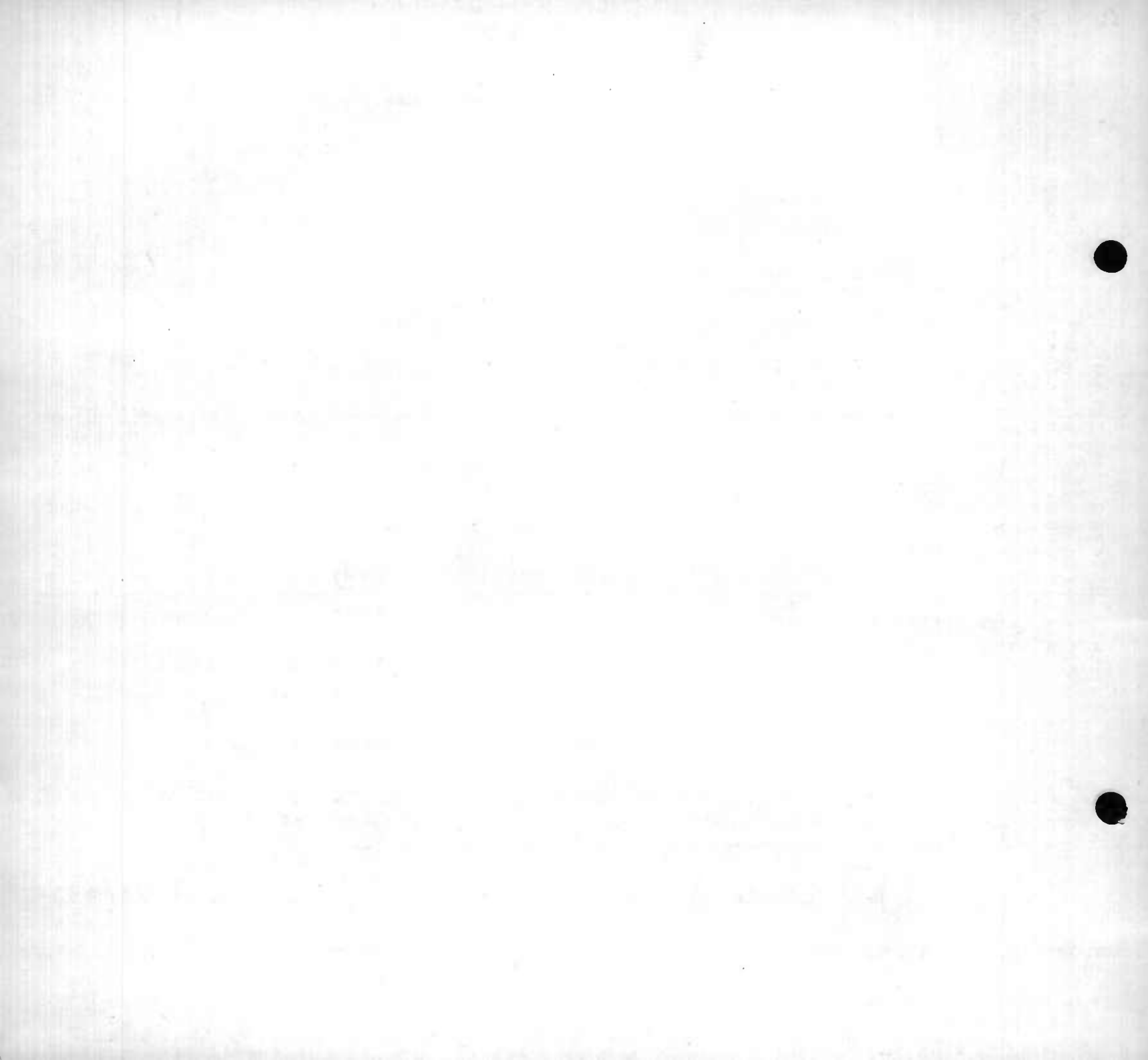
BIRTH NO. 67 5457		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5457	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Jessie B. Wagner		2. DATE AND HOUR OF DEATH 6-5-67 1 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY	
00 4252 Shamrock Avenue		D. STREET ADDRESS (If rural, give location)		26-02 4252 Shamrock Avenue	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married (Separated)	8. DATE OF BIRTH Nov. 8, 1903.	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee		10B. KIND OF BUSINESS OR INDUSTRY Maxwell Oil Co.		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clarence S. Fielding		14. MOTHER'S MAIDEN NAME Belle Manning	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 013-14-0433		17. INFORMANT ADDRESS Mrs. Dorothy I. Freyer 5704 Anthony Ave.	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Coronary insufficiency DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1957 to June 5, 1967, that (I) (we) last saw the deceased alive on June 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Donald Jandorf		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-5-67	
23C. PHYSICIAN'S NAME (Type) R. Donald Jandorf M.D.		23D. ADDRESS 6077 Harford Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/8/67		24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.	
24D. LOCATION Balto. Md.		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

VS 150-REV. 1/1/65

67 5458		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5458	
BIRTH NO. 67-04955					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) CANDACE RAE BRITAIN			2. DATE AND HOUR OF DEATH MAY 28, 1967 8:45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 48 md. GEN. HOSP.			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 21205 26-34		
D. STREET ADDRESS 1010 QUANTREIL WAY			9. AGE (in years last birthday)		
5. SEX FEMALE			6. RACE WHITE		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NB.			8. DATE OF BIRTH MAY 26, 1967		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME RONNIE BLAIR BRITAIN			14. MOTHER'S MAIDEN NAME MARTINA SUE BIGGS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT mother			ADDRESS SAME		
18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) RESPIRATORY FAILURE DUE TO (B) PREMATUREITY DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 35 hrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work Not While At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 26 19 67 to MAY 28 19 67 that (I) (we) last saw the deceased alive on MAY 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 5/28/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-1-67		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION		ANATOMY BOARD OF MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUN 7 1967		[Signature]		MORTUARY SERVICE - BCHD	



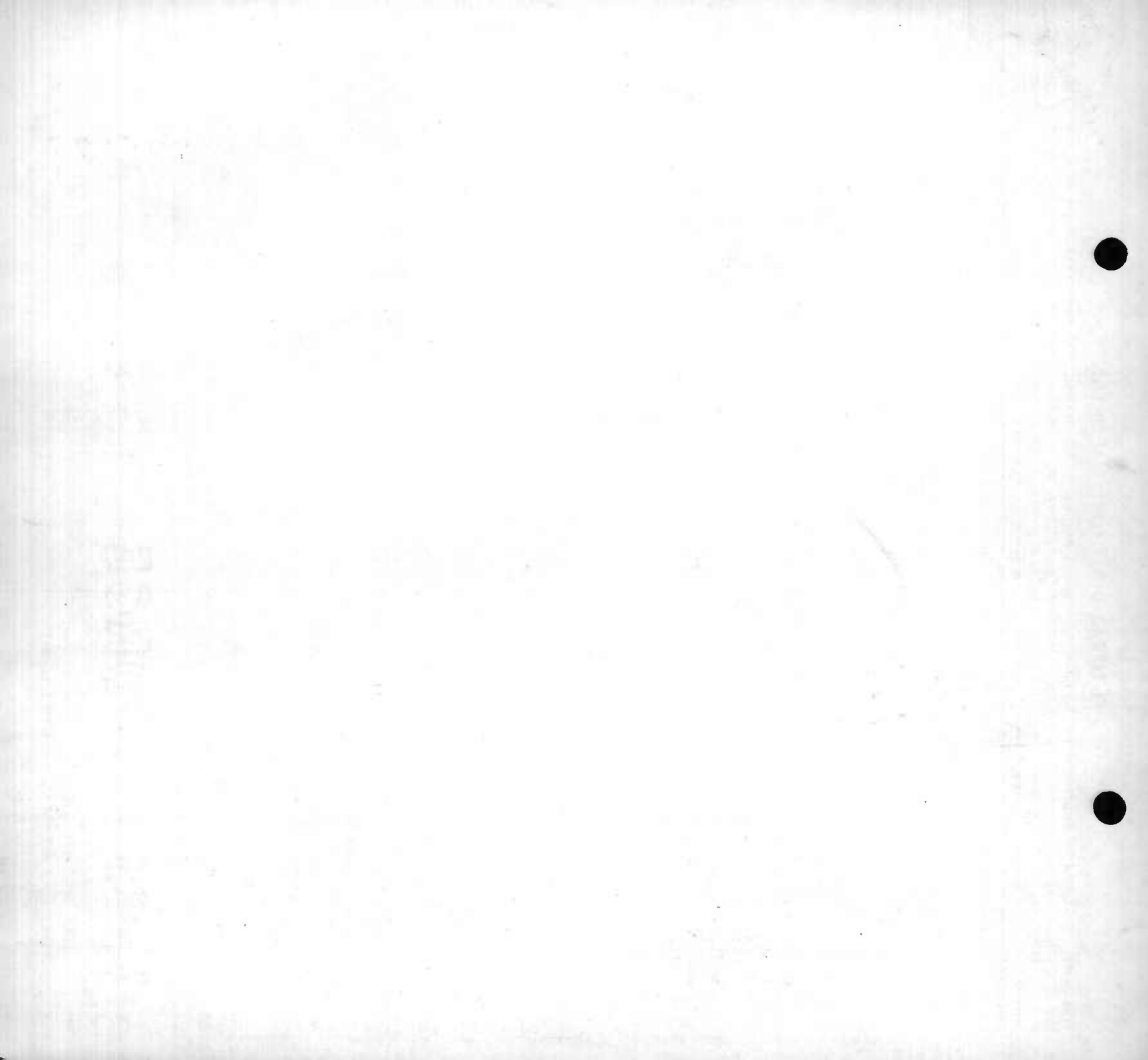
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5460		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5460	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAM BLACKMAN		2. DATE AND HOUR OF DEATH 5/27/67 11:55 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 67 FRANKLIN SQUARE HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) 18-02 D. STREET ADDRESS (If rural, give location) 107 N. CAREY ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 67?	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 309X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CHRONIC BRAIN SYNDROME DUE TO (B) BRONCHOPNEUMONIA DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 5/26 1967 to 5/27 1967, that (I) (we) last saw the deceased alive on 5/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE DR. KRAVITZ		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/27/67	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS FRANKLIN SQ. HOSP.		23E. CITY, TOWN, OR COUNTY BALTIMORE, MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-2-67		24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL	
24D. LOCATION MORTUARY SERVICE - BCHD		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR JUN 7 1967	
24G. NAME OF REGISTRAR		24H. FUNERAL DIRECTOR		24I. ADDRESS	



1
P-630

67 5461

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 5461

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES J. PORTWAY

2. DATE AND HOUR PRONOUNCED DEAD

May 21, 1967

4:50 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1111 E. Baltimore Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

3-02

D. STREET ADDRESS (If rural, give location)

1111 E. Baltimore Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Lobar pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

(Partial)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 21, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

6-5-67

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

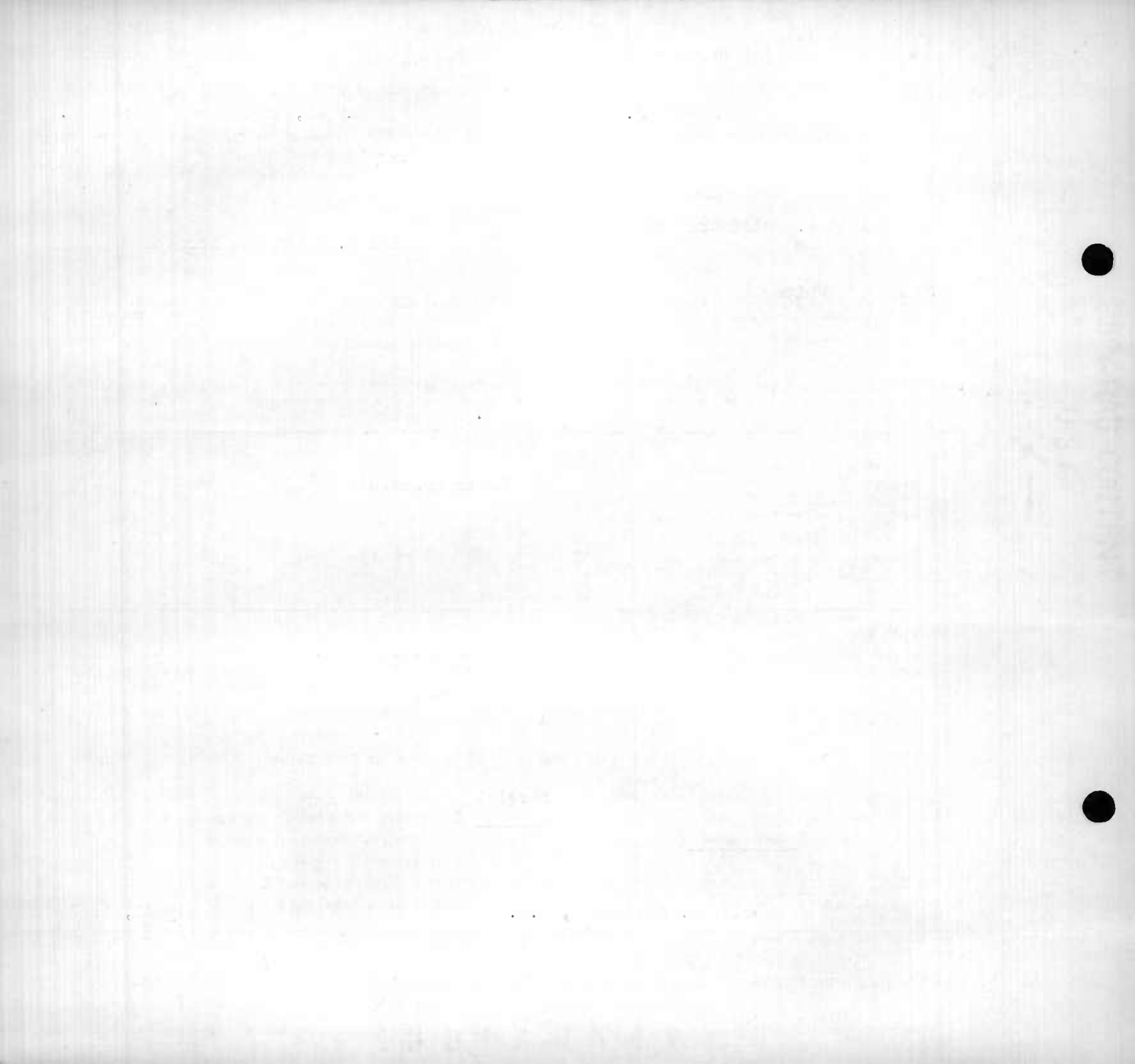
24C. FUNERAL DIRECTOR

ADDRESS

JUN 7 1967

Robert E. Taylor, M.D.

MORTUARY SERVICE - BCHD



1
B-620

67 5462

BALTIMORE CITY HEALTH DEPARTMENT

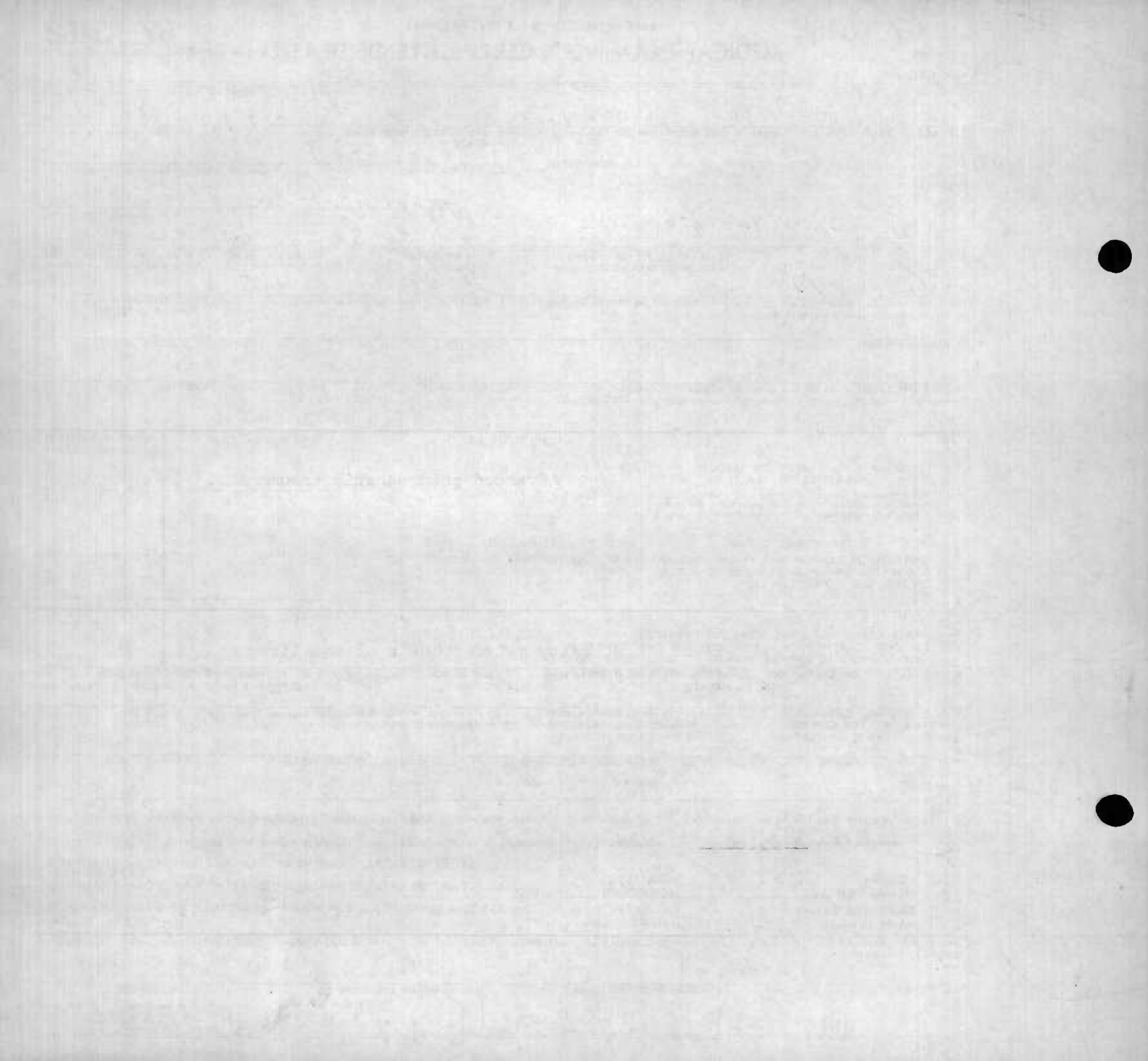
67 5462

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

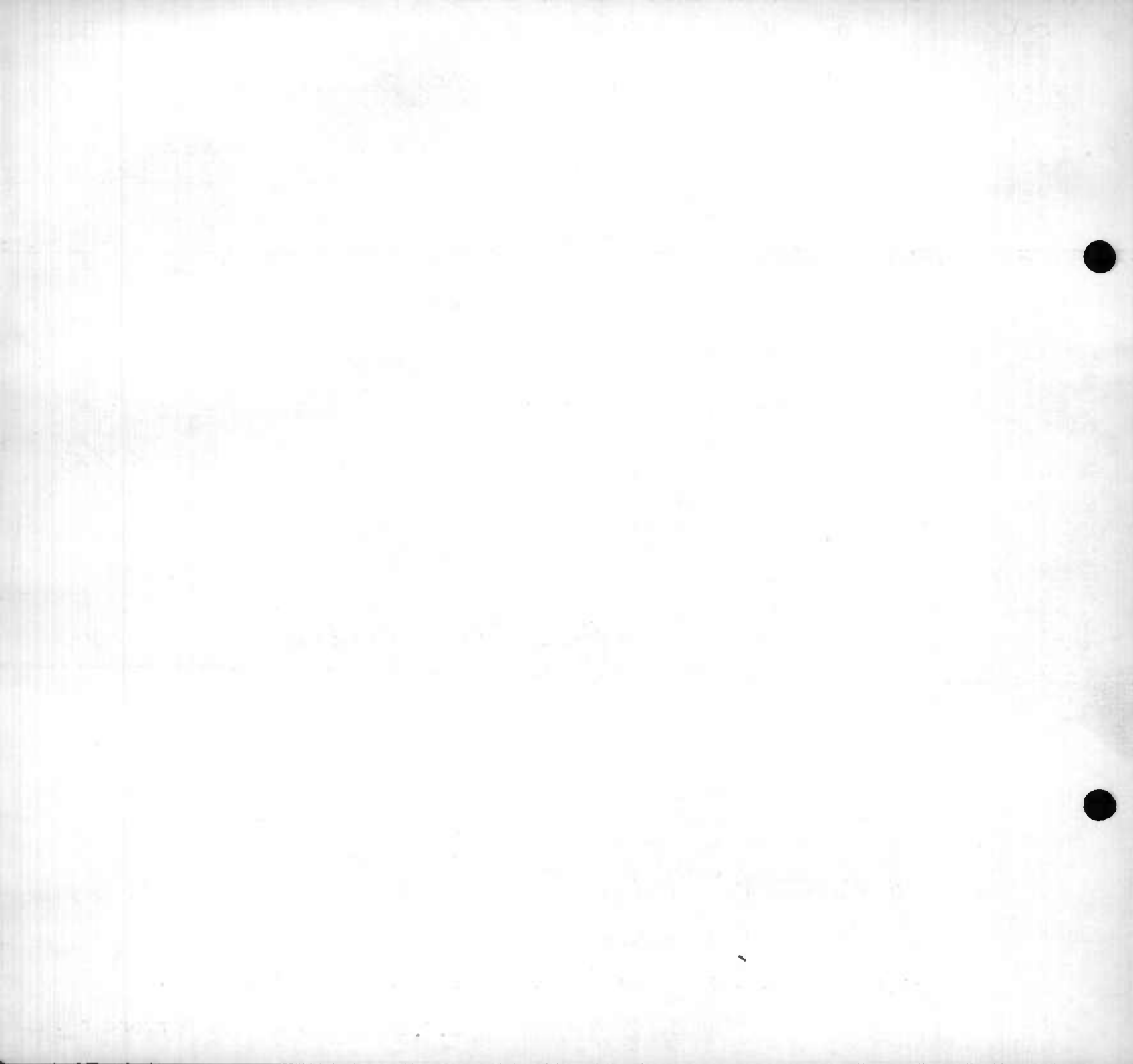
1. NAME OF DECEASED (Type or Print) ALPHONSO G. BERWICK		2. DATE AND HOUR PRONOUNCED DEAD 5/18/67 9:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 22-02	
D. STREET ADDRESS (If rural, give location) ST. MORRIS HOTEL			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 3/29/04
9. AGE (In years last birthday) 63		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. 473X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Advanced pneumococcal pneumonia (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty metamorphosis of the liver (C) DUE TO			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John E. Adams EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED MAY 19, 1967			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE 6-5-67	
23C. NAME OF CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL	
24A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		24B. NAME OF REGISTRAR R. E. E. Taylor	
24C. FUNERAL DIRECTOR		24D. ADDRESS HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

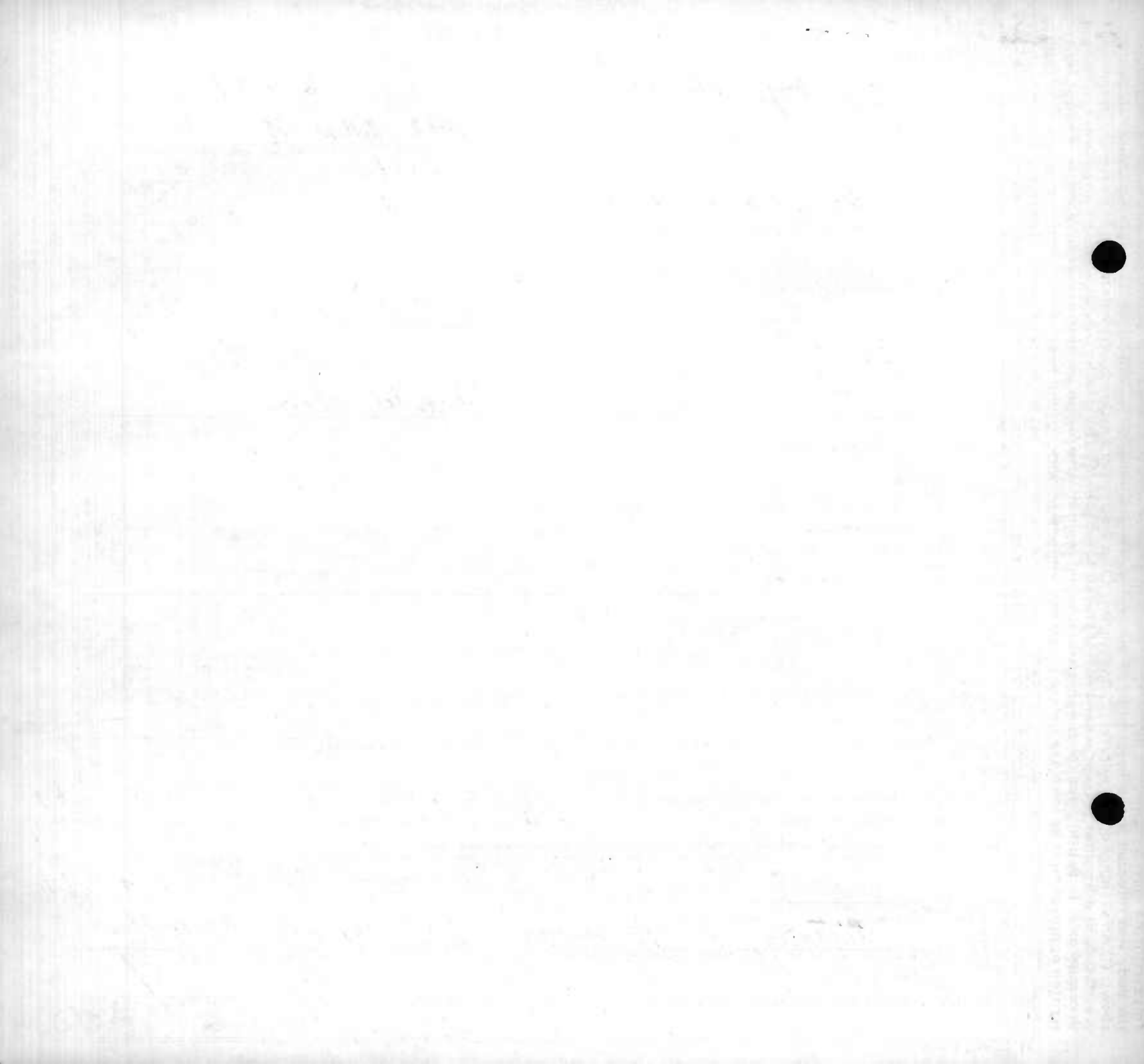
BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 67 5463					CERTIFICATE OF DEATH					Registered No. 67 5463						
1. NAME OF DECEASED (Type or Print) <i>Reid, Maraian Brother C.F.</i>										2. DATE AND HOUR OF DEATH <i>May 31, 1967 7:05 P. M.</i>						
3. PLACE OF DEATH IN "BALTIMORE, MARYLAND"										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>						
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Jenkins Memorial Hospital</i> <i>1000 Caton Avenue</i> <i>Baltimore, Md. 21229</i>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>4403 Frederick Avenue</i>						
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <i>1-16-1894</i>		9. AGE (In years lost birthday) <i>73</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Teacher</i>		11. BIRTHPLACE (State or foreign country) <i>Detroit, Michigan</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>Nelson Reid</i>										14. MOTHER'S MAIDEN NAME <i>Margaret Hoban</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-54-2405</i>		17. INFORMANT <i>Brother John Edward</i>				ADDRESS <i>4403 Frederick Ave</i>						
18. <i>493X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pneumonia</i>										CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>										OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Brain Syndrome</i>					<i>2 yrs</i>	
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?								
22. I certify that (H) (this hospital) attended the deceased from <i>May 25, 1967</i> to <i>5/31, 1967</i> , that (I) (we) lost saw the deceased alive on <i>5/31, 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.																
23A. SIGNATURE <i>J. Raymond Gladue</i> M.D.										Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/31/67</i>				
23C. PHYSICIAN'S NAME (Type) <i>J. Raymond Gladue</i> M.D.										23D. ADDRESS						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-3-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sacred Heart Nov. Cem.</i>				24D. LOCATION (City, town, or county) (State) <i>Leonardtwn Md.</i>								
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 7 1967</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>				25C. FUNERAL DIRECTOR ADDRESS <i>G.F. EVANS & SON 8802 Harford rd.</i>								



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		67 5464		67 5464	
M.E. CASE NO. 67-11005					
1. NAME OF DECEASED (Type or Print) <i>BOY BOY DRINNON</i>			2. DATE AND HOUR OF DEATH <i>6-4-67 8:57 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bow seconds Hospital</i>			A. STATE <i>MD</i> B. COUNTY <i>2000 23</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 19-03</i>		
			D. STREET ADDRESS (If rural, give location) <i>MD</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>6-4-67</i>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10B. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME <i>BILLY DRINNON</i>			14. MOTHER'S MAIDEN NAME <i>JANEY JOHNSON</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Hospital Records</i>
18. <i>776X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Immaturity</i> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6-4-67</i> to <i>6-4-1967</i> , that (I) <i>(we)</i> last saw the deceased alive on <i>6-4-1967</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>Aleude A. Melocaton</i> M.D.				23B. DATE SIGNED <i>6-4-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALEUDE A MELOCATON</i> M.D.				23D. ADDRESS <i>BOW SECONDS HOSPITAL</i>	
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/6/67</i>		24C. NAME OF CEMETERY or CREMATORY <i>St Peter's Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 7 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. Edwards</i>		25C. FUNERAL DIRECTOR <i>James J. Berry</i>	
				ADDRESS <i>(Baltimore)</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5465	
BIRTH NO. 67 5465		M.E. CASE NO. 67-10148			
1. NAME OF DECEASED (Type or Print) Girl MARTIN, TRIPLET "C"		2. DATE AND HOUR OF DEATH 5/24/67 11:30 a.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL 34		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto 15-38			
D. STREET ADDRESS (If rural, give location) 3402 Piedmont Ave					
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 5/23/67	9. AGE (In years last birthday) 2 days 45 min	10. If Under 1 Yr. Months: Days: Hours: Min. 25 hr 45 min
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Richard MARTIN, JR.			
14. MOTHER'S MAIDEN NAME SAUNITA HINKSON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records		ADDRESS	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Immaturity (B) Due to (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/23/67 19 67 to 5/24/67 19 67, that (I) (we) last saw the deceased alive on 5/24/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chung K. Bae M.D.		23B. DATE SIGNED 5/24/67			
23C. PHYSICIAN'S NAME (Type) CHUNG K. BAE M.D.		23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/1/67		24C. NAME OF CEMETERY OR CREMATORY St Peter Cn	
24D. LOCATION (City, town, or county) Balto Md					
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Thomas J. Kennedy		25C. FUNERAL DIRECTOR Thomas J. Kennedy INC Balto Md	

my

leave to Hinson

to Hinson

ATTENTION

ATTENTION

ATTENTION

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

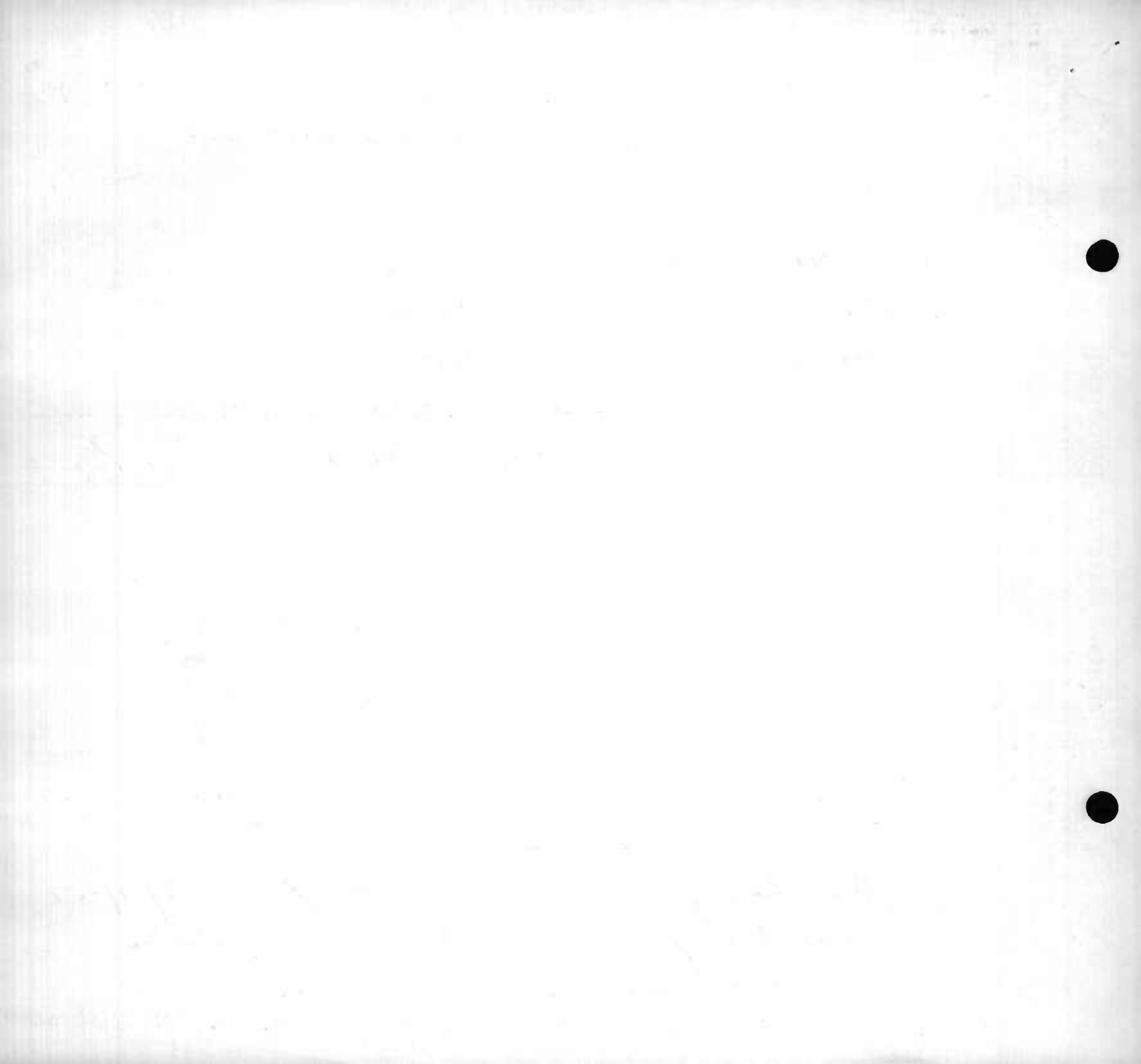
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 67 5466		CERTIFICATE OF DEATH		67 5466	
M.E. CASE NO. 67 5466		1. NAME OF DECEASED (Type or Print) <i>Boy Martin</i>		2. DATE AND HOUR OF DEATH <i>5-27-67 12:30 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>BON Secours Hospital</i>		A. STATE <i>BALTO-MD</i>		B. COUNTY <i>BALTO-MD</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
5. SEX <i>M</i>		6. RACE <i>C</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	
8. DATE OF BIRTH <i>5-23-67</i>		9. AGE (in years last birthday) <i>3</i>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Richard Martin Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Isabelita Henken</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>3402 Piedmont Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Perinatal</i>		<i>3 days + 15 hrs</i>	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5-23</i> 19 <i>67</i> to <i>5-27</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>5-27</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Alexander A. Melocoton</i> M.D.		23B. DATE SIGNED <i>5-27-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALEXANDER A. MELOCOTON</i> M.D.		23D. ADDRESS <i>BON SECOURS HOSP.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/6/67</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St Peter's Cem</i>	
24D. LOCATION (City, town, or county) <i>BALTO MD</i>		24E. STATE (State) <i>MD</i>			
25A. DATE REC'D. BY HEALTH DEPT. <i>JUN 7 1967</i>		25B. NAME OF REGISTRAR <i>DR. J. E. FADEN</i>		25C. FUNERAL DIRECTOR <i>Thomas J. Henry</i> ADDRESS <i>BALTO MD</i>	

bm

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

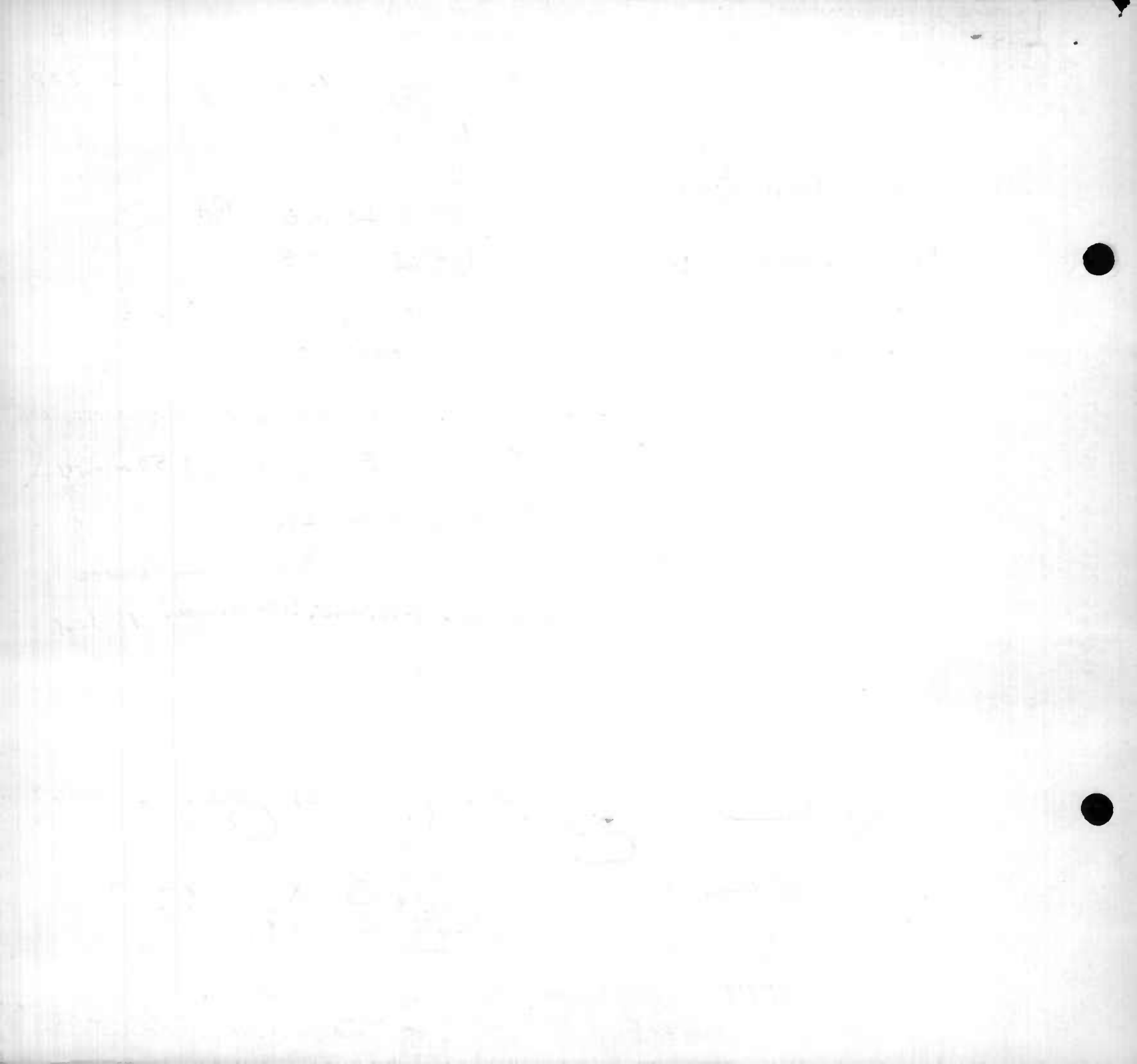
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5467	
BIRTH NO. 67 5467				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>IDA HERMAN</u>			2. DATE AND HOUR OF DEATH <u>6/4/67</u> <u>2:45 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI Hospital of Baltimore</u> <u>4-2</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3020 Virginia Avenue</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>88</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Borah Cramer</u>			14. MOTHER'S MAIDEN NAME <u>Yenza ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-48-8729</u>	17. INFORMANT <u>Mr. Julius Isaacson, 111 Equitable Building</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 + years</u>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>6/3</u> <u>1967</u> to <u>6/4</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>6/4</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Abe Levy</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/4/67</u>
23C. PHYSICIAN'S NAME (Type) <u>ABE LEVY</u>			23D. ADDRESS M.D. <u>Sinai Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/5/67</u>	24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Friendship</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert D. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>[Sol] Levinson & Bros. Inc., 6010 Reisterstown</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5468	
BIRTH NO. 67 5468		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH 6/4/67 2:20 P.M.	
1. NAME OF DECEASED (Type or Print) Sarah (Resig) RAITZYK		2. DATE AND HOUR OF DEATH	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital 46		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3518 Langrehr Rd.	
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 3/4/02
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 65
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME DAVID SIMON		14. MOTHER'S MAIDEN NAME IDA MARV ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-3517D	
17. INFORMANT Mrs. Shirley Nehlman, 8544 Stevenswood Road		ADDRESS	
18. 463X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Phlebitis, Right Leg.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Cerebrovascular Accident, Left Hemisphere 16 days.	
INTERVAL BETWEEN ONSET AND DEATH 50 minutes		?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 18, 1967 to June 4, 1967 , that (I) (we) last saw the deceased alive on June 4, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert C. Blackmon, M.D.		23B. DATE SIGNED 6/4/67	
23C. PHYSICIAN'S NAME (Type) Robert C. Blackmon, M.D.		23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67	
24C. NAME OF CEMETERY or CREMATORY Beth Israel		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR 6077 Remington		ADDRESS 6077 Remington	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

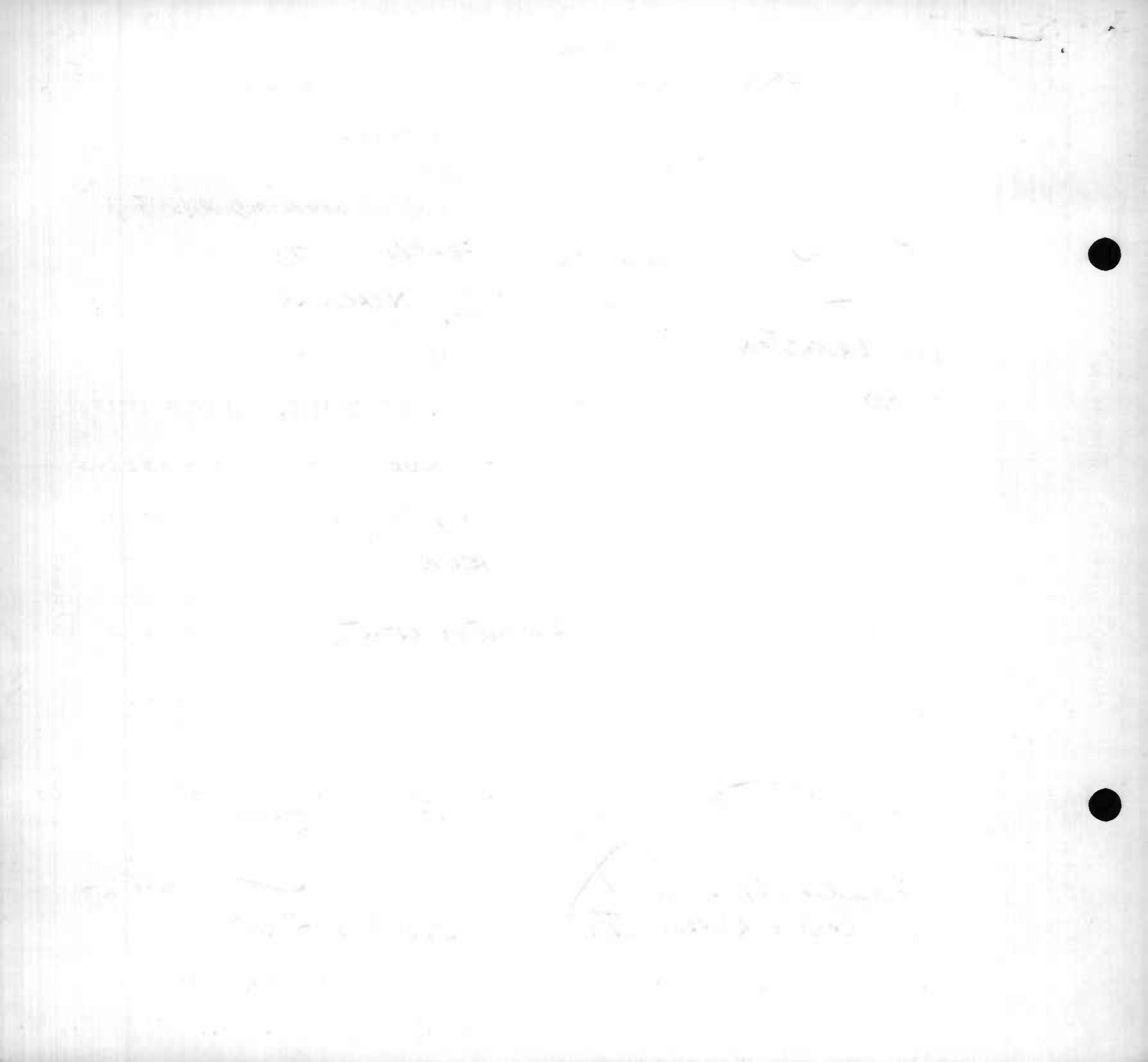
BALTIMORE CITY HEALTH DEPARTMENT										
67 5469					Registered No. 67 5469					
CERTIFICATE OF DEATH										
BIRTH NO.		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
					SKOLNIK, ELSIE			6/4/67 3:25 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY					
42 SINAI HOSPITAL OF BALTO.					MA. US.					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
					BALTIMORE 27-15					
					D. STREET ADDRESS (If rural, give location)					
					2419 EVERTON Rd #9					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
WF	W	MARRIED		5/15/99	68					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
HOUSEWIFE		AT HOME			RUMANIA		USA			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
MORRIS GEFFEN					UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO				NO		MR. JACK SKOLNIK, 2419 EVERTON ROAD #9				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH					
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0					No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>								
22. I certify that (X) (this hospital) attended the deceased from 5/30 1967 to 6/4 1967, that (X) (we) lost saw the deceased alive on 6/4 1967 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.										
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED		
P. Gann								6/4/67		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS					
MARK GANN.					sinai hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
Burial		6/5/67		BETH TFILOH,			BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS					
JUN 7 1967		Robert E. Taylor			SQL LEVINSON & BROS. INC., 6010 REIST., RD.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 67 5470	
IRTH NO. 67 5470 M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>FANNY KIRSON</i>				2. DATE AND HOUR OF DEATH <i>6-2-67</i> <i>3 35</i> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>SINAI Hosp. of BALTO, INC</i> <i>42</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTO</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>6665 SANZO ROAD</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i>	8. DATE OF BIRTH XXXXXX	9. AGE (In years last birthday) <i>73</i>	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Elizabeth City N. CAROLINA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>LOUIS LAUENSTEIN</i>				14. MOTHER'S MAIDEN NAME <i>BALA ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT ADDRESS <i>MRS. BEVERLY FINE, 6531 COPPERFIELD ROAD</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO <i>CUA.</i> (B) DUE TO <i>HYPERTENSION</i> (C) <i>ASCVD.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>42 days.</i> <i>> 1 year</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>RHEUMATOID ARTHRITIS</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4-20-65</i> 19 <i>65</i> to <i>6-2</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>6-2</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Ceslie Abramowitz</i>				23B. DATE SIGNED <i>6-2-67</i>		23C. PHYSICIAN'S NAME (Type) <i>Ceslie ABRAMOWITZ</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6/4/67</i>		24C. NAME of CEMETERY or CREMATORY <i>BNAI ISRAEL</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 7 1967</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>SSL LEVINSON & BROS. INC., 6010 REIST., RD.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5471	
67-10147 BIRTH NO. 67 5471		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Girl Baby Martin Triplet B		2. DATE AND HOUR OF DEATH 5/24/67 3 15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-38			
		D. STREET ADDRESS (If rural, give location) 3402 Piedmont Ave			
5. SEX F	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5/23/67	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Richard Martin			
14. MOTHER'S MAIDEN NAME Jannita Hinkson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/23/67 to 5/24/67, that (I) (we) last saw the deceased alive on 5/24/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chung K. Bae M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) CHUNG K. BAE M.D.				23D. ADDRESS BON SECOURS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/5/67		24C. NAME of CEMETERY or CREMATORY St Peters Cm	
24D. LOCATION (City, town or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967			
25B. NAME OF REGISTRAR James E. Taylor, MD		25C. FUNERAL DIRECTOR James J. Kenny Jr. Book Mgr			

bm

hall

—

FOR-72000 HOSPITAL

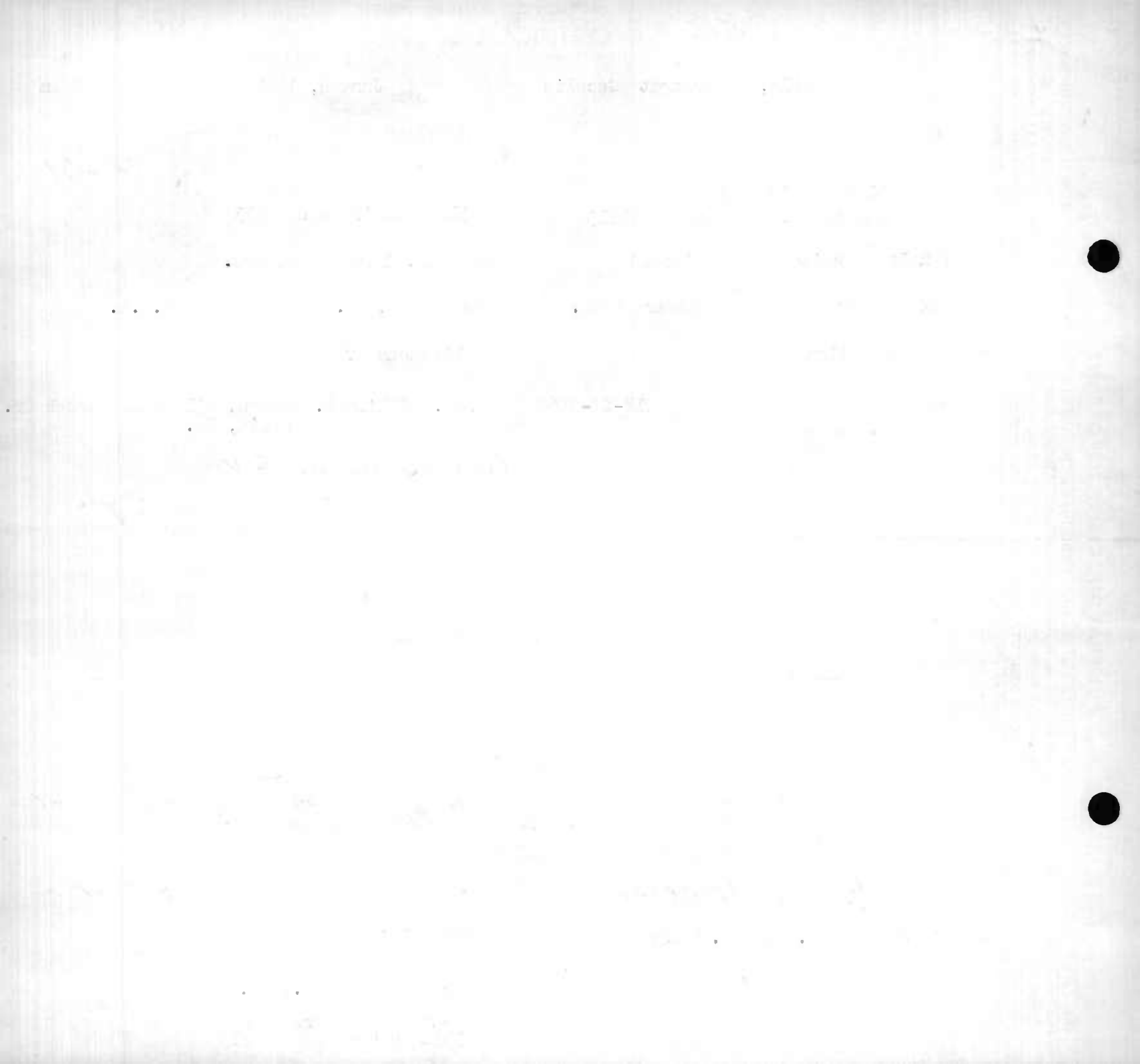
WINDY & COLD

5-3401

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5472	
BIRTH NO. 67 5472		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Stehle, Margaret Cecelia	
2. DATE AND HOUR OF DEATH June 4, 1967		8 am M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3107 Belair Road Baltimore, Maryland 21213		A. STATE Maryland		B. COUNTY	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		8-01	
		D. STREET ADDRESS (If rural, give location) 3107 Belair Road #13			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH July 11, 1886	9. AGE (In years last birthday) 80 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady		10B. KIND OF BUSINESS OR INDUSTRY Stewart & Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Peter Fallon		14. MOTHER'S MAIDEN NAME Elizabeth ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-22-2569		17. INFORMANT Mrs. William E. Howard, 831 Ridley Creek Dr. Media, Pa.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Anterior wall M.I. Disease		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II		(C) DUE TO			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work Not White At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 19 65 to June 19 67, that (I) (we) last saw the deceased alive on 6-2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Duer J. Moore		M.D. Attending Phys. Med. Director Staff Phys.		23B. DATE SIGNED 6-5-67	
23C. PHYSICIAN'S NAME (Type) Dr. Duer J. Moore		23D. ADDRESS 3105 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/7/67		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 7 1967		24F. NAME OF REGISTRAR Robert E. Falcus	
24G. FUNERAL DIRECTOR Schimunek Funeral Home		24H. ADDRESS 3331 Brehms Lane #13			



10-500 67 5473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 5473

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 67 5473		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Alfred M. Owen		2. DATE AND HOUR OF DEATH June 3, 1967 5:20 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1609 Freedom Way North 21213 007	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-1-04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switch Board Operator		10B. KIND OF BUSINESS OR INDUSTRY Marylander Apts.	9. AGE (In years last birthday) 63
11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Owen		14. MOTHER'S MAIDEN NAME Mary Ann Armstrong	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 411-05-1081	
17. INFORMANT Carrie Owen, wife, above		ADDRESS #21224 BCH: Records 4940 Eastern Ave. Baltimore, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarct		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ASVD	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5/29 1967 to 6/3 1967, that (I) (we) last saw the deceased alive on 6/2 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (do not) view the body after death.			
23A. SIGNATURE Monica M. Buckley			23B. DATE SIGNED 6/3/67
23C. PHYSICIAN'S NAME (Type) Monica M. Buckley			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/6/67	24C. NAME OF CEMETERY or CREMATORY Blue Ridge Memorial Gardens	24D. LOCATION (City, town, or county) (State) Prosperity, West Va.
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967	25B. NAME OF REGISTRAR Robert E. Tanaka	25C. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13	

Handwritten text, possibly a signature or date, located in the upper middle section of the page.

Handwritten text, possibly a signature or date, located in the lower right section of the page.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

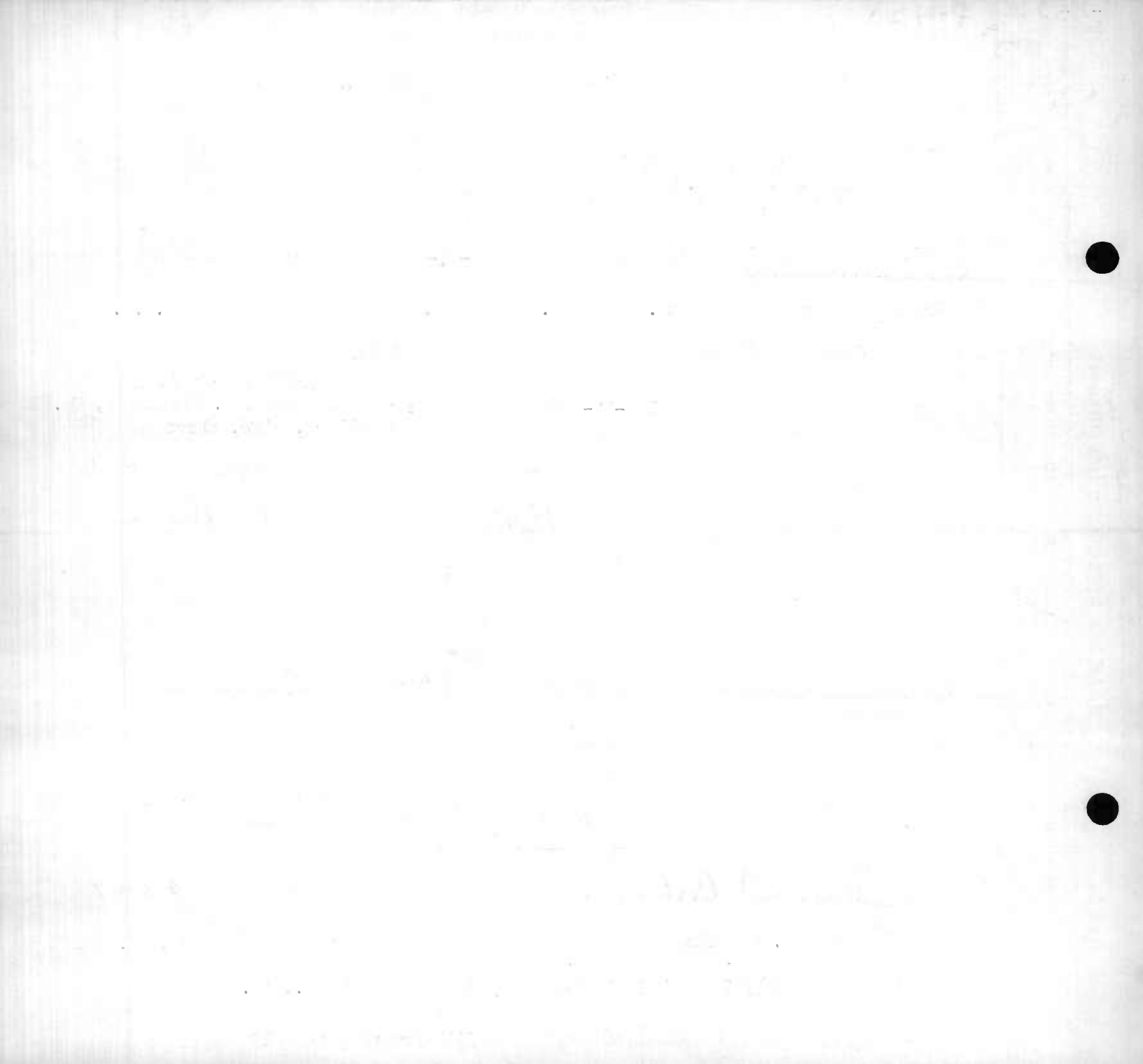
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5474	
BIRTH NO. 67 5474		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Caroline A. Siatkowski		2. DATE AND HOUR OF DEATH 6-3-67 9:40 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital		A. STATE Maryland B. COUNTY			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3215 McElderry St. #5			
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Feb. 2, 1886	9. AGE (In years last birthday) 81 yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? no		13. FATHER'S NAME Peter Puc		14. MOTHER'S MAIDEN NAME Katherine	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Adam J. Siatkowski, husband, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X14-204.3		CAUSE OF DEATH (A) DUE TO Diabetic Acidosis (B) DUE TO Subacute Myelogenous Leukemia (C) _____		INTERVAL BETWEEN ONSET AND DEATH day 3	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Pneumonia; Renal Failure		Interval between onset and death unknown	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-2 1967 to 5-3 1967, that (I) (we) lost saw the deceased alive on 5-3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodelio M. Jim		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-3-67	
23C. PHYSICIAN'S NAME (Type) Rodelio M. Jim		23D. ADDRESS Church Home & Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/7/67	24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR John E. Farley		25C. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13	
ADDRESS					

manipulation of the data
in the field

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-420 67 5475 CERTIFICATE OF DEATH		Registered No. 67 5475	
BIRTH NO. 67 5475 M.E. CASE NO. _____ 1. NAME OF DECEASED (Type or Print) George M. Pollock		2. DATE AND HOUR OF DEATH 6-3-67 7:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3400 Dudley Avenue #21213	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-27-08
9. AGE (In years lost birthday) 59		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Pollock		14. MOTHER'S MAIDEN NAME Anna Miklos	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 162-18-7860	
17. INFORMANT Baltimore City Hospitals		ADDRESS RECORDS: 4940 Eastern Ave. Baltimore, Md. #24	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 473X		CAUSE OF DEATH Mary Pollock, wife, above INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Intracerebral hemorrhage DUE TO (B) Hypertensive Cardiovascular Disease DUE TO (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 6-1-1967 to 6-3-1967 , that (H) (we) last saw the deceased alive on 6-3-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE James T. Corkins		23B. DATE SIGNED 6-3-67	
23C. PHYSICIAN'S NAME (Type) James T. Corkins		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/7/67	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Q.225 E. Farkas	
25C. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 3331 Brehms Lane #13	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5476				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5476	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN DOMBKOWSKI				2. DATE AND HOUR OF DEATH JUNE 5, 1967 12:05 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 234 S. PATTERSON PARK AVE.				A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 234 S. PATTERSON PARK AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 5/15/91	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME PIATEK (DECEASED)				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 21805-9868		17. INFORMANT HELEN WARMINSKI		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 4431			CAUSE OF DEATH (A) Cerebral Vascular Accident (B) Hypertensive C. V.D. (C) Cerebral Vascular Disease			INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from Jan. 1966 to June 5, 1967 , that (I) (we) lost saw the deceased alive on June 4, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. J. Jaworski				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/6/67	
23C. PHYSICIAN'S NAME (Type) M. J. JAWORSKI				23D. ADDRESS 2711 Eastern Ave. Bldg 24			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/9/67		24C. NAME of CEMETERY or CREMATORY HOLY ROSARY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR John M. Weber & Sons, Inc.		25C. FUNERAL DIRECTOR ADDRESS 401 S. CHESTER ST.			

2-1-1914
2-1-1914
2-1-1914

2-1-1914
2-1-1914
2-1-1914

2-1-1914

2-1-1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Baltimore City Health Department	
BIRTH NO. 67 5477				Registered No. 67 5477	
1. NAME OF DECEASED (Type or Print) STEFANIA MIECKOWSKI STEPHANIE MIECKOWSKI				2. DATE AND HOUR OF DEATH 6-4-1967	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 626 S. KENWOOD AVE.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 626 S. KENWOOD AVE.	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 11-17-1898	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ADAMKOWSKI			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 096-12-5447		
17. INFORMANT RELCHESTER MIECKOWSKI			ADDRESS 408 S. CHESTER ST.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral ASCOT Pneumonia			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 weeks		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1962 to June 4 19 67 . that (I) (we) last saw the deceased alive on June 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore T. Niznik				23B. DATE SIGNED 6-5-67	
23C. PHYSICIAN'S NAME (Type) T. T. NIZNIK M.D.				23D. ADDRESS 429 S. Charles St.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-8-1967		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CHURCH	
24D. LOCATION (City, town, or county) BALTIMORE		24E. LOCATION (City, town, or county) MARYLAND		24F. LOCATION (City, town, or county) BALTIMORE	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Stephens		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC.	
25D. ADDRESS 401 S. CHESTER ST.					

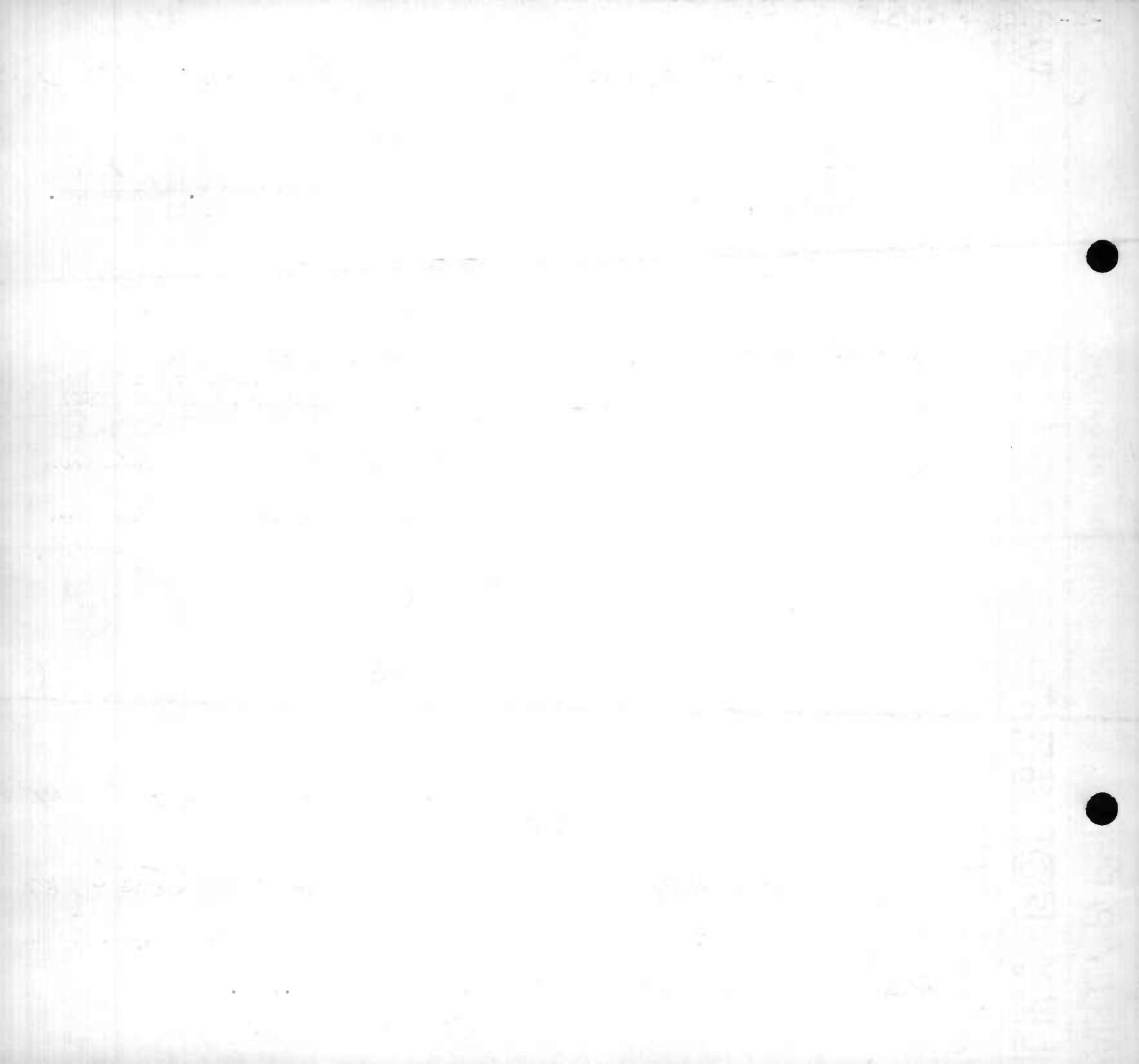
CERTIFICATE OF DEATH

BIRTH NO. 10-255 67 5478		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) Mary BOSSMAN		2. DATE AND HOUR OF DEATH JUNE 4, 1967 8:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-03 D. STREET ADDRESS (If not give location) Formerly of 701 N. Belnord Ave. 3919 Lyndale Avenue #21213	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 1-10-1884
9. AGE (In years last birthday) 83		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leopold Steigerwald (Deceased)		14. MOTHER'S MAIDEN NAME (Deceased) Gertrude Kunkel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-03-9272 D	
17. INFORMANT BCH 4940 Eastern Avenue		18. RECORDS: Baltimore, Maryland #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Diabetes Mellitus		Interval between onset and death Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/16 19 67 to 6/4 19 67 , that (I) (we) last saw the deceased alive on 6/4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE D. Tarsy		23B. DATE SIGNED JUNE 4, 1967	
23C. PHYSICIAN'S NAME (Type) Daniel Tarsy		23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 6/8/67	24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	24D. LOCATION (City, town, or county) (State) Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Tarsy	
25C. FUNERAL DIRECTOR Schimunek Funeral Home		ADDRESS 1331 Brehms Lane #13	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Di. 2-4900



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5479		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5479	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Anthony Zubrowski</i>		2. DATE AND HOUR OF DEATH <i>6-3-67 6:45 AM</i> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>21224</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> 1-01	
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>34 Bon Secours Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>829 S. DECKER AVE</i>			
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>6-17-05</i>	9. AGE (In years lost birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Sexton</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>FRANK Zubrowski</i>		14. MOTHER'S MAIDEN NAME <i>Catherine ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT ADDRESS <i>Mrs. Catherine Zubrowski 829 S. Decker Ave., Baltimore Md.</i>	
18. <i>540.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Generalized peritonitis</i> DUE TO		<i>3-4 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Disruption of anastomosis - (gastrojejunostomy)</i> DUE TO		<i>3-4 days</i>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>Pneumonitis of lower lobes, bilat.</i>		<i>3 days</i>	
19A. DATE OF OPERATION <i>5-29-67</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>PELVIC OBSTRUCTION</i>	20A. AUTOPSY? (Yes or No) <i>yes</i>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>May 26, 1967</i> to <i>June 3, 1967</i> , that (I) (we) last saw the deceased alive on <i>June 3, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jorge B. Joaquin</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <i>June 3, 1967</i>		
23C. PHYSICIAN'S NAME (Type) <i>JORGE B. JOAQUINO</i>		23D. ADDRESS <i>Bon Secours Hospital, Balto. MD. Z#23</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6-6-67</i>	24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 7 1967</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	25C. FUNERAL DIRECTOR <i>Nicholas T. Matthews</i>		ADDRESS <i>3021 Eastern Ave., Baltimore, Md.</i>	

Handwritten text, possibly a signature or name, located in the upper center of the page.

Handwritten text, possibly a date or a short phrase, located in the lower center of the page.

Handwritten text, possibly a date or a short phrase, located in the lower center of the page.

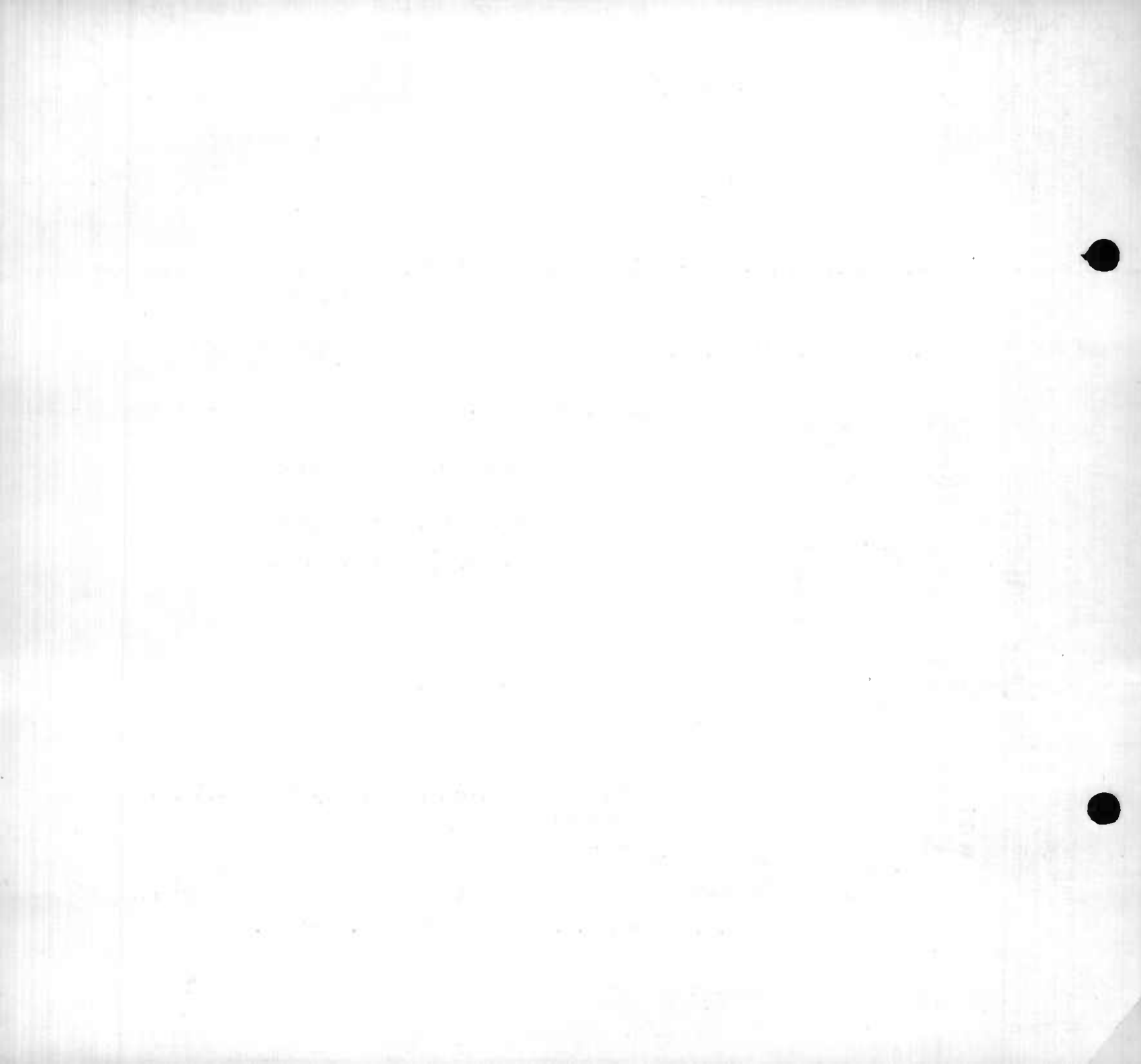
Handwritten text, possibly a date or a short phrase, located in the lower right corner of the page.

B-2101

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		67 5480		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.		67 5480	
M.E. CASE NO.				CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)				MRS. ROXANNA DUVALL BAGBY		2. DATE AND HOUR OF DEATH Monday-June-5-1967 7:45 AM M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Maryland Baltimore City					
90 Gaddes Nursing Home		211 Ridgewood Road 21210		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 27-13			
D. STREET ADDRESS (If rural, give location)		5801 Roland Av (21218)							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Female	White	Married	Feb-5-1895	72	none	St. Margaret's, Md.	U.S.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Dr. Wirt A. Duvall				Roxana Louise Mitchell					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		no		217-03-9244		Mm. Hugh Bagby (husband) 5801 Roland Av-21210			
18. 443X I		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		(A) Cerebral Hemorrhage					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Hypertensive Cardio-					
				(C) vascular disease					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 2 June 1967 to 5 June 1967, that (I) (we) last saw the deceased alive on 4 June 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		5 June 67			
23C. PHYSICIAN'S NAME (Type)		Anderson M. Kenick, M.D.		23D. ADDRESS		1010 St. Paul St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
burial		June-7-67		Loudon Park		Baltimore 21229			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUN 7 1967		Robert E. Jenkins		Seward & Son		21201			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5481				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5481	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Yick Kee		6/5/67 12:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
90 Bolton Hill Nursing Home				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore Maryland 14-01	
D. STREET ADDRESS (If rural, give location)				1615 Park Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
Male	Chinese	-?-	4/8/84	83			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cook		Theater		probably China		-?-	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
-?-				-?-			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				165-12-7405		Mrs Lee-10034 Parkers Ch-21202	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
cerebro-vascular accident				(A) DUE TO		immediate	
thrombosis				(B) DUE TO		"	
A.S.C.V.D.				(C) DUE TO		several yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Urinary & fecal incontinence		several months.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 23, 19 67 to June 5, 1967 that (I) (we) last saw the deceased alive on 6-4-19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook M.D.						23B. DATE SIGNED 6-6-67	
23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK M.D.				23D. ADDRESS 2131 Maryland Avenue, Balto. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial June 6/67		June 6/67		Lorraine		Woodlawn	
25A. DATE RECEIVED BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR E. E. Ellsworth		25C. FUNERAL DIRECTOR		ADDRESS	

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

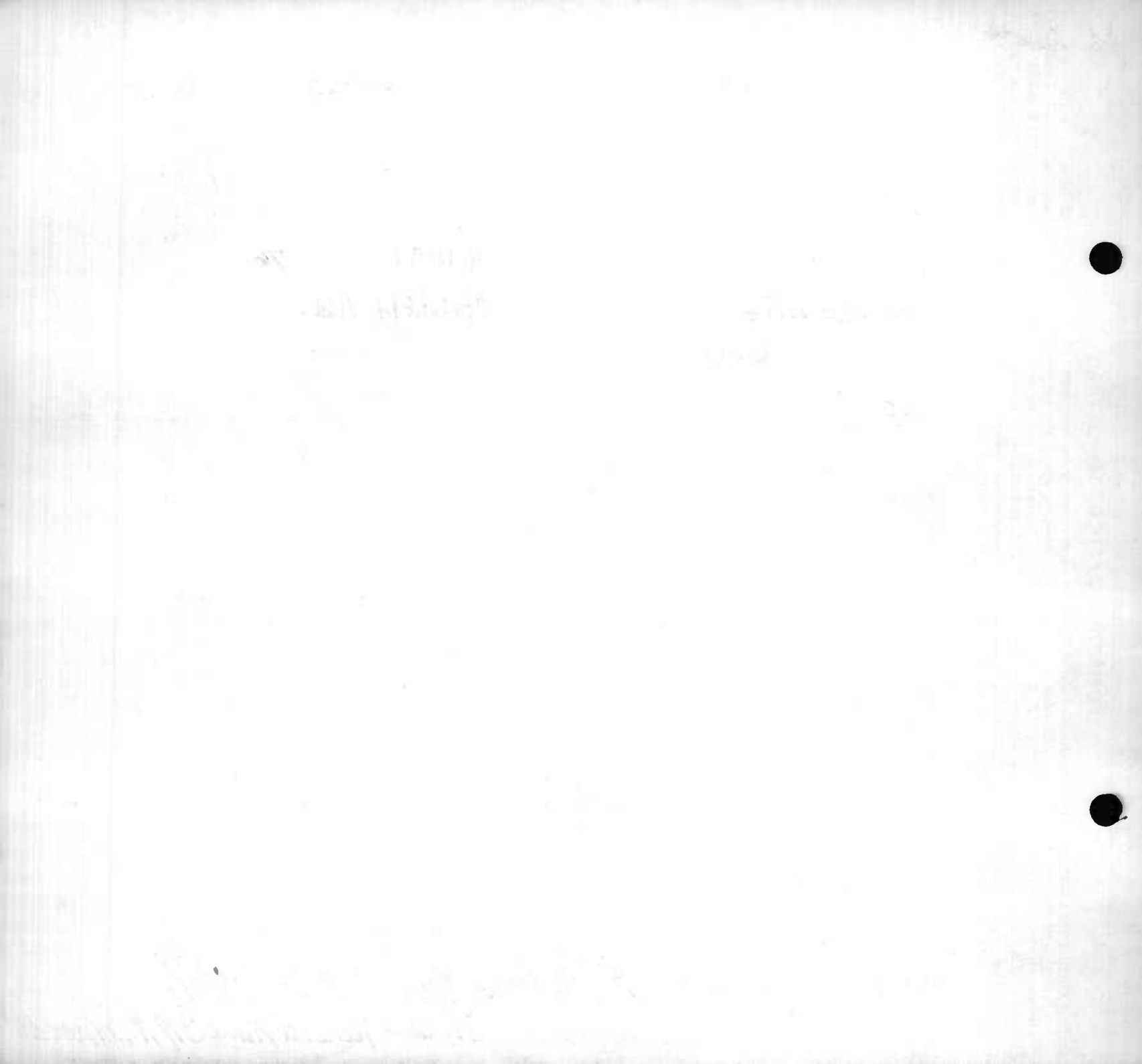
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5482	
BIRTH NO. 67 5482		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Smith, Gilbert		5 June 1967 7 30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Lincoln Memorial Nursing Home		A. STATE Maryland C. CITY OR TOWN Severn D. STREET ADDRESS 52-00	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 1/16/1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 62
13. FATHER'S NAME William H. Smith		11. BIRTHPLACE (State or foreign country) AA County, Md.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 212-18-7102		14. MOTHER'S MAIDEN NAME Gertrude ?	
17. INFORMANT Mrs. Lillie Gibis, Severn, Md.		ADDRESS	
18. 153.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Carcinoma of Colon		CAUSE OF DEATH (A) Carcinoma of Colon DUE TO (B) _____ DUE TO (C) _____	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 31 May 1967 to 5 June 1967 , that (I) (we) last saw the deceased alive on 4 June 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Hennis Sennarune		23B. DATE SIGNED 5 June 1967	
23C. PHYSICIAN'S NAME (Type) Hennis Sennarune		23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 June 67	
24C. NAME of CEMETERY or CREMATORY Ivy Hill Cemetery		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE RECEIVED JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR W. Kirkley		ADDRESS Kirkley Funeral Home, Glen Burnie, Md.	

James Thompson
June 28, 1882

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 67 5483					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 67 5483				
1. NAME OF DECEASED (Type or Print) ELLA DUTTON					2. DATE AND HOUR OF DEATH 6-5-67 121 NOON M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSP.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 903 BOARMAN AVE.				
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 4-11-91	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Christfield Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME CHARLES CORBIN					14. MOTHER'S MAIDEN NAME ANNIE HOLDON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT MARIE DUTTON S/A.		ADDRESS DAUGHTER		
18. 204.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. LEUKEMIA					CAUSE OF DEATH (A) CVA DUE TO (B) LEUKEMIA DUE TO (C) 2 YRS.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 6-5-67 to 6-5-67 , that (1) (we) last saw the deceased alive on 6-5-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Michael R. Siegel					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6-5-67		
23C. PHYSICIAN'S NAME (Type) MICHAEL R. SIEGAL					23D. ADDRESS UNIVERSITY HOSP.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/9/1967		24C. NAME OF CEMETERY or CREMATORY MT Auburn Cem. Balto. Md.		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR R. B. SE. Fudge		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Howard St.			



H-655

67 5484

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5484

1. NAME OF DECEASED (Type or Print) HAZELTON		2. DATE AND HOUR PRONOUNCED DEAD June 3, 1967 1:35 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 903 W. SARATOGA STREET 00		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY X C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 903 W. Saratoga Street Apt. 10	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH Aug. 14, 1900
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Bor'to. Md.	
13. FATHER'S NAME William Harmon		14. MOTHER'S MAIDEN NAME Annie Payne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 186-14-2859	
17. INFORMANT Gerla Dawson		ADDRESS 902 W. Mulberry St	
18. CAUSE OF DEATH 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/3/67 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) Burial		23B. DATE 6/7/67	
23C. NAME of CEMETERY or CREMATORY Mt Calvary Cem. Cedar Hill Md.		23D. LOCATION (City, town or country) (State) Md.	
24A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		24B. NAME OF REGISTRAR Robert E. Johnson	
24C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 347 N. Broadway	

CONFIDENTIAL

SECRET

11/11/11

11/11/11

CONFIDENTIAL

SECRET

SECRET

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						Registered No. <u>67 5485</u>	
BIRTH NO. <u>67 5485</u>		M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>WEED FRANK S</u>				2. DATE AND HOUR OF DEATH <u>JUNE 4 1967</u> <u>1:10 P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <u>ST AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>4421 ALAN DR. APT E</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>WIDOWED</u> <u>DIVORCED</u> (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>6-21-86</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouseman-retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Acme Stores</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>DAVID S. Wood</u>				14. MOTHER'S MAIDEN NAME <u>RACHAEL SAUDER Souder</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212070199</u>		17. INFORMANT ADDRESS <u>ST AGNES HOSPITAL CATON & WILKENS AVE.</u>		
18. <u>3-59-1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive Heart Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Esophageal Stricture</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>6-4-67</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (IX) (this hospital) attended the deceased from <u>MAY 26 1967</u> to <u>JUNE 4 1967</u> , that (IX) (we) last saw the deceased alive on <u>JUNE 4 1967</u> and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (and not) view the body after death.							
23A. SIGNATURE <u>John B Herts</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-4-67</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN B HERTS</u>				23D. ADDRESS M.D. <u>CATON & WILKENS AVE. BALTIMORE MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/7/67</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard 4107 Wilkens Ave. 21229</u>			

5-10-5

JUNE 1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

1955

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5486				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5486	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Rosalind McDowell</u>				2. DATE AND HOUR OF DEATH <u>June 4, 1967</u> <u>8:35 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>BALTO MD</u> B. COUNTY <u>Crownsville ST</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>A.A.Co. 52-00</u>			
D. STREET ADDRESS (If rural, give location)							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>1/24/90</u>	9. AGE (In years lost birthday) <u>77</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Betty Atkinson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>287-28-6291A</u>		17. INFORMANT <u>MaDonoThy F Richardson</u>		ADDRESS <u>Silver Spring Md.</u>	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease or injury or complication which caused death.) <u>Myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>advanced age</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>May 31</u> 19 <u>67</u> to <u>June 4</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 4</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>James D. Shargaw</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>June 4, 1967</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/6/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hershey Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Hershey Penna</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 7 1967</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>J.F. Flinn & Sons Tricesters Town Md</u>			

THE UNIVERSITY OF CHICAGO
LIBRARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 67 5487					CERTIFICATE OF DEATH					Registered No. 67 5487				
1. NAME OF DECEASED (Type or Print) MAURICE GARFIELD BAUBLITZ										2. DATE AND HOUR OF DEATH 7:45 AM 6/8/67				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSPITAL BALTO. MD.										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD., VI B. COUNTY BALTO. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) UPPERCO D. STREET ADDRESS (If rural, give location) 53-00				
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M		8. DATE OF BIRTH 8/1/13		9. AGE (In years last birthday) 53		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPPING CLERK					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) USA BALTO. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES BAUBLITZ					14. MOTHER'S MAIDEN NAME ELVA ARMA COST									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 213-05-0434					17. INFORMANT JEANNETTE BAUBLITZ S/A				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) CARCINOMA OF LUNG DUE TO (B) CHRONIC BRONCHITIS + EMPHYSEMA DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH 15 mos.				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5/21/67 19 to 6/8/67 19, that (I) (we) lost saw the deceased alive on 6/8/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Stuart L. Fine, M.D.										23B. DATE SIGNED 6/8/67				
23C. PHYSICIAN'S NAME (Type) STUART, L. FINE M.D.										23D. ADDRESS UNIV OF MD HOSP.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6/7/67		24C. NAME of CEMETERY or CREMATORY Grace Cemetery					24D. LOCATION (City, town, or county) (State) Upperco Md.				
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967					25B. NAME OF REGISTRAR Robert E. [Signature]					25C. FUNERAL DIRECTOR Tipton, Eline Funeral Home Hampstead, Md.				

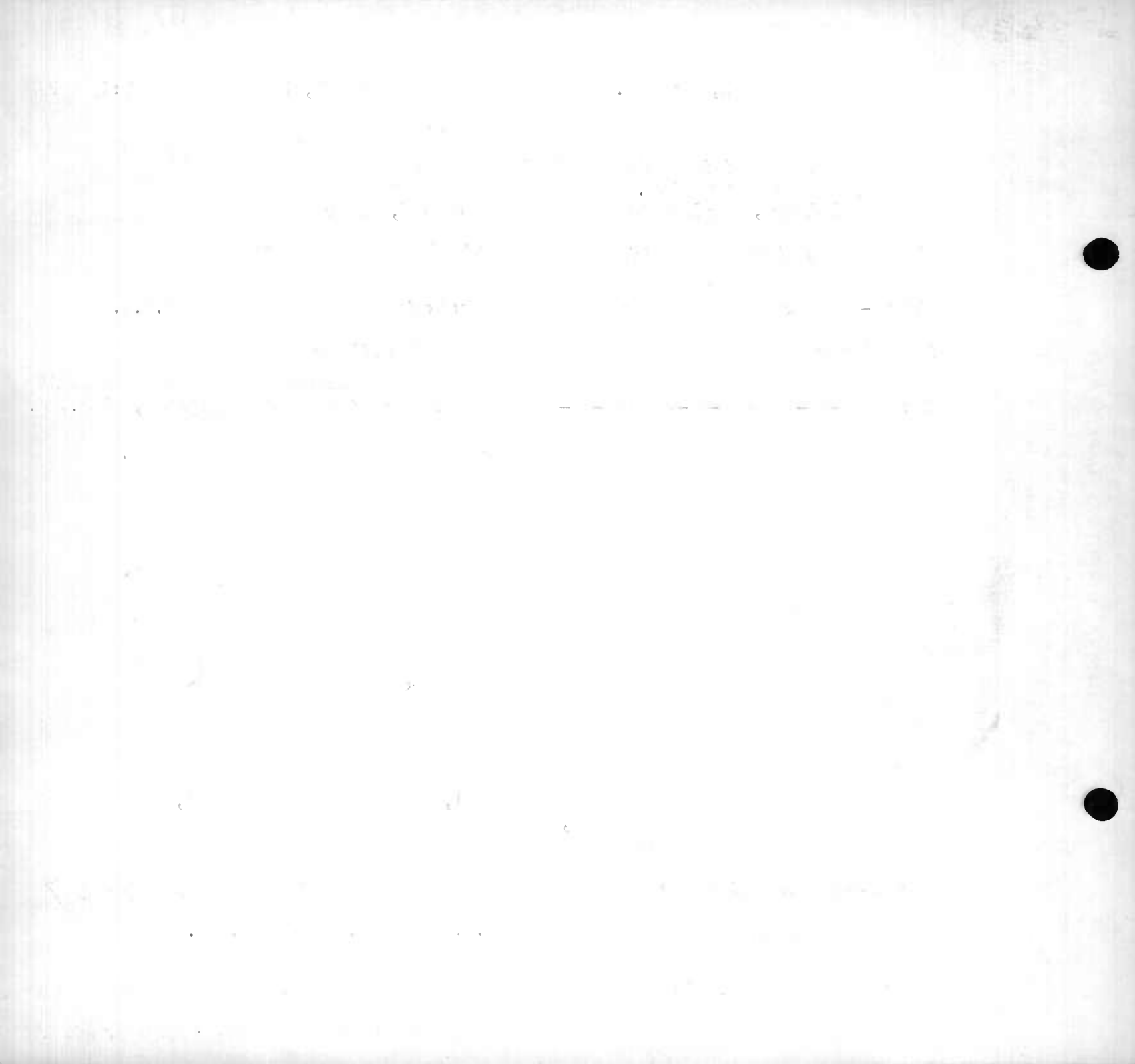
Carte No.

Carte No. 12.2

12-2-12

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5488				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5488	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FIGUEROY, Henry C.				2. DATE AND HOUR OF DEATH June 4, 1967 7:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				A. STATE Maryland B. COUNTY Harford			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Edgewood 62-00			
				D. STREET ADDRESS (If rural, give location) Box 145, Cedar Lane			
5. SEX Male		6. RACE Caucasian		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 4/20/93	
						9. AGE (In years lost birthday) 74	
						If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Laborer				10B. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Silas Figueroy				14. MOTHER'S MAIDEN NAME Anna Fischmiller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4-15-18 to 4-10-19				16. SOCIAL SECURITY NO. 183-18-8432		17. INFORMANT Records ADDRESS 21218 Veterans Administration Hospital, Balto., Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 331X I Subdural Hematoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from June 1, 1967 to June 4, 1967, that (X) (we) last saw the deceased alive on June 4, 1967 and that in (My) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sung Ill Shin M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 6-4-67	
23C. PHYSICIAN'S NAME (Type) Sung Ill Shin						23D. ADDRESS M.D. V.A. Hospital, Baltimore, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 7, 1967		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Overlea Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 67 5489
CERTIFICATE OF DEATH										
BIRTH NO. 67 5489										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) CHARLES D. CARRICO					2. DATE AND HOUR OF DEATH 6-1-67 4:20 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) 3 THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 D. STREET ADDRESS (If rural, give location) 311 E. BURKE AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 01-15-04	9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER-OWNER			10B. KIND OF BUSINESS OR INDUSTRY PAINT STORE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JAMES CARRICO					14. MOTHER'S MAIDEN NAME RACHEL BURTON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE			16. SOCIAL SECURITY NO. 214-20-4534		17. INFORMANT ADDRESS					
18. 45-1X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEMORRAGE FROM STRESS ULCER INTERVAL BETWEEN ONSET AND DEATH 1 hour.										
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE RENAL FAILURE 10 days. RESECTION OF ABD. AORTIC ANEURYSM 10 days.										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CHRONIC LUNG DISEASE, RESP. ARREST.										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5-27 1967 to 6-1 1967 , that (I) (we) last saw the deceased alive on 6-1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23A. SIGNATURE Carlos R. Hamilton Jr. M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6-1-67		
23C. PHYSICIAN'S NAME (Type) CARLOS R. HAMILTON JR M.D.					23D. ADDRESS THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/5/67		24C. NAME OF CEMETERY or CREMATORY GRACE METHODIST		24D. LOCATION (City, town, or county) (State) COCKEYSVILLE MD.				
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Talbot			25C. FUNERAL DIRECTOR ADDRESS John Barnes Sons Towson					

Carlos R. Hamilton Jr.
CARLOS R. HAMILTON JR THE JOHNS HOPKINS HOSPITAL

CHICKENSVILLE MD.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 67 5490		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 67 5490	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EVERETT J. CRIDER		2. DATE AND HOUR OF DEATH 6-5-67 9:55 p.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore Co.			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - Edgemere 53-00			
		D. STREET ADDRESS (If rural, give location) 2404 ESTELLE AVE			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 5-9-14	9. AGE (in years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rod mill finisher		10B. KIND OF BUSINESS OR INDUSTRY Beth Steel		11. BIRTHPLACE (State or foreign country) VA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JAMES CRIDER		14. MOTHER'S MAIDEN NAME Audrey LOVELACE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-1645		17. INFORMANT (Wife) CARRIE CRIDER	
				ADDRESS S/A	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) 7-20-11		CAUSE OF DEATH (A) DUE TO Cardiac arrest (B) DUE TO Asystole (C) Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 45 min 1 minute 5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-31-67 19 to 6-5 19 67 , that (I) (we) lost saw the deceased alive on 6-5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE TK Gray		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-5-67	
23C. PHYSICIAN'S NAME (Type) TK GRAY		23D. ADDRESS Maryland General Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/9/67		24C. NAME of CEMETERY or CREMATORY David Brooks Family Plot Cem.	
				24D. LOCATION (City, town, or county) Spottsylvania County, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR John J. Duda	
				ADDRESS 7922 Wise Ave. Dundalk, Md.	

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

100-1000

B-634

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 5491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5491

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Arthur Bradley

2. DATE AND HOUR PRONOUNCED DEAD

June 4 67 8:18 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

31 City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

FLORIDA

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

LAKE WORTH

V-08

D. STREET ADDRESS (If rural, give location)

826 Cochran Drive

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JAN 11 1906

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

ELECTRICIAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

OHIO

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HOWARD A. BRADLEY

14. MOTHER'S MAIDEN NAME

ADELAIDE HEISS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL
SECURITY NO.

167-09-2110

17. INFORMANT

IRENE BRADLEY

ADDRESS

ABOVE

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arterio Sclerotic Cardio-
Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

M. D. [Signature]

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6.4.67

23A. BURIAL CREMATION,
REMOVAL (Specify)

REMOVAL

23B. DATE

6/6/67

23C. NAME of CEMETERY or CREMATORY

LAKE WORTH

23D. LOCATION

(City, town, or county)

LAKE WORTH

(State)

FLA

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

EE. SMITH & SON

305 MACE

LAKE WORTH FLA

MADE IN U.S.A.

MADE IN U.S.A.

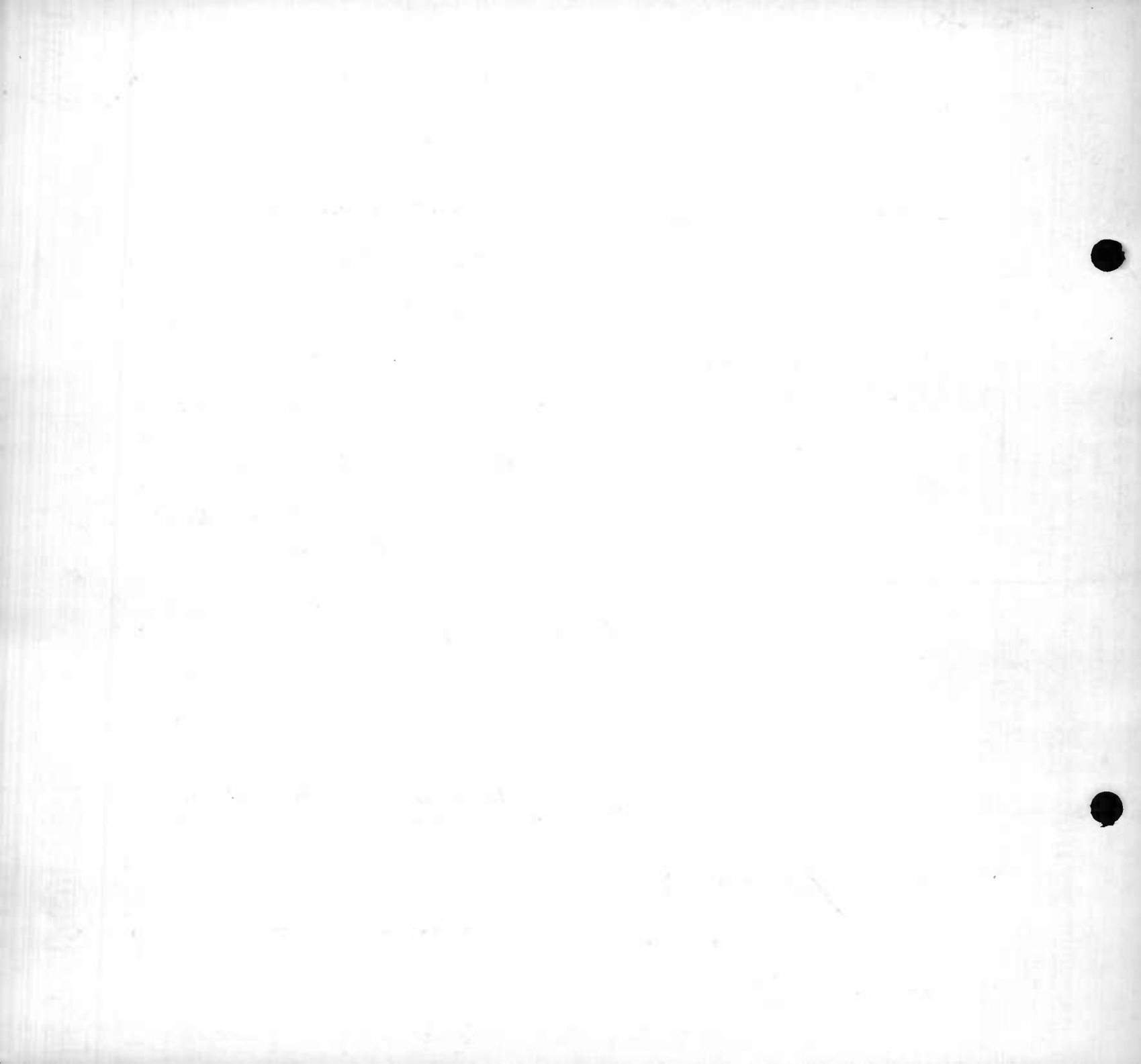
MADE IN U.S.A.

MADE IN U.S.A.

Name: Lucas: Raymond
 Date: 6/3/67 Time: 7:12
 Hy# 124 6665
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 67 5492					CERTIFICATE OF DEATH					
M.E. CASE NO.					Registered No. 67 5492					
1. NAME OF DECEASED (Type or Print) <u>SETH RAYMOND LUCAS</u>					2. DATE AND HOUR OF DEATH <u>6/3/67</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS</u>					A. STATE <u>MD.</u>					
(If not in hospital or institution, give street address or location)					B. COUNTY <u>BALTO.</u>					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					<u>26-10</u>					
D. STREET ADDRESS (If rural, give location)					<u>3327 E. MONUMENT</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 27, 1902</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CITY</u>		11. BIRTHPLACE (State or foreign country) <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>EDWIN LUCAS</u>					14. MOTHER'S MAIDEN NAME <u>SARAH HOBAN</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK</u>			16. SOCIAL SECURITY NO. <u>214-40-6356</u>		17. INFORMANT <u>MARY LUCAS</u>		ADDRESS <u>ABOVE</u>			
18. <u>42017-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>					INTERVAL BETWEEN ONSET AND DEATH <u>hours.</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes Mellitus.</u>					(B) <u>Arteriosclerotic Cardiovascular Disease.</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C)					
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>June 4th</u> 19 <u>65</u> to <u>June</u> 19 <u>67</u> and that (I) (we) last saw the deceased alive on <u>May 30</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Joe Martinez</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>6-5-67</u>		
23C. PHYSICIAN'S NAME (Type) <u>Jose Martinez, M.D.</u>					23D. ADDRESS <u>100 N. Broadway - Baltimore, Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/7/67</u>		24C. NAME OF CEMETERY or CREMATORY <u>GARDENS OF FAITH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>				
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR <u>967000</u>			25C. FUNERAL DIRECTOR <u>J. E. CONNELLY SONS</u>			ADDRESS <u>300 MACE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 67 5493	
BIRTH NO. 67 5493		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mary D. Phillips		2. DATE AND HOUR OF DEATH 6.5.67 12 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hohns Hopkins Hospital 33				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21220 53-00 D. STREET ADDRESS (If rural, give location) 1210 SECOND RD.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH SEPT 1, 1915	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENN.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FINNEFROCK				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ?		17. INFORMANT RICHARD PHILLIPS		ADDRESS 339 NICHOLSON	
18. 163X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Congestive Heart Failure Prob. Pulm. CARCinoma		INTERVAL BETWEEN ONSET AND DEATH onwee	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from 6.1.67 19 to 6.5.67 19, that (I) (<u>we</u>) last saw the deceased alive on 6.5.67 19 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death.							
23A. SIGNATURE Robert M. Winslow				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6.5.67	
23C. PHYSICIAN'S NAME (Type) Robert M. Winslow				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/8/67		24C. NAME of CEMETERY or CREMATORY HOLLY HILL		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR 1967000		25C. FUNERAL DIRECTOR J. J. CONNELLY SONS		ADDRESS 300 MACE	

1210 Second St.
San Francisco 21-20
Sept 1, 1912

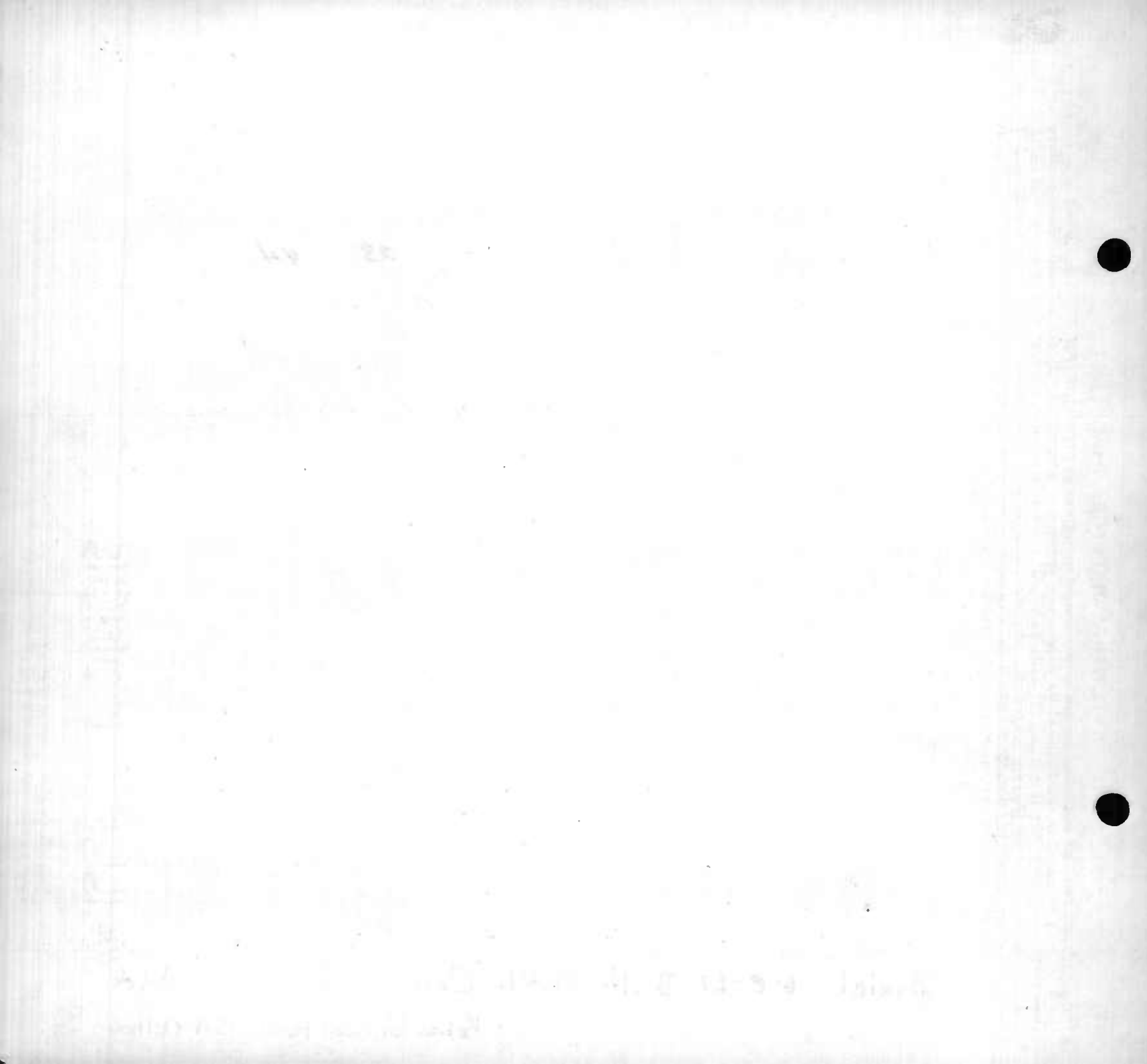
Yes

Robert M. M. M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

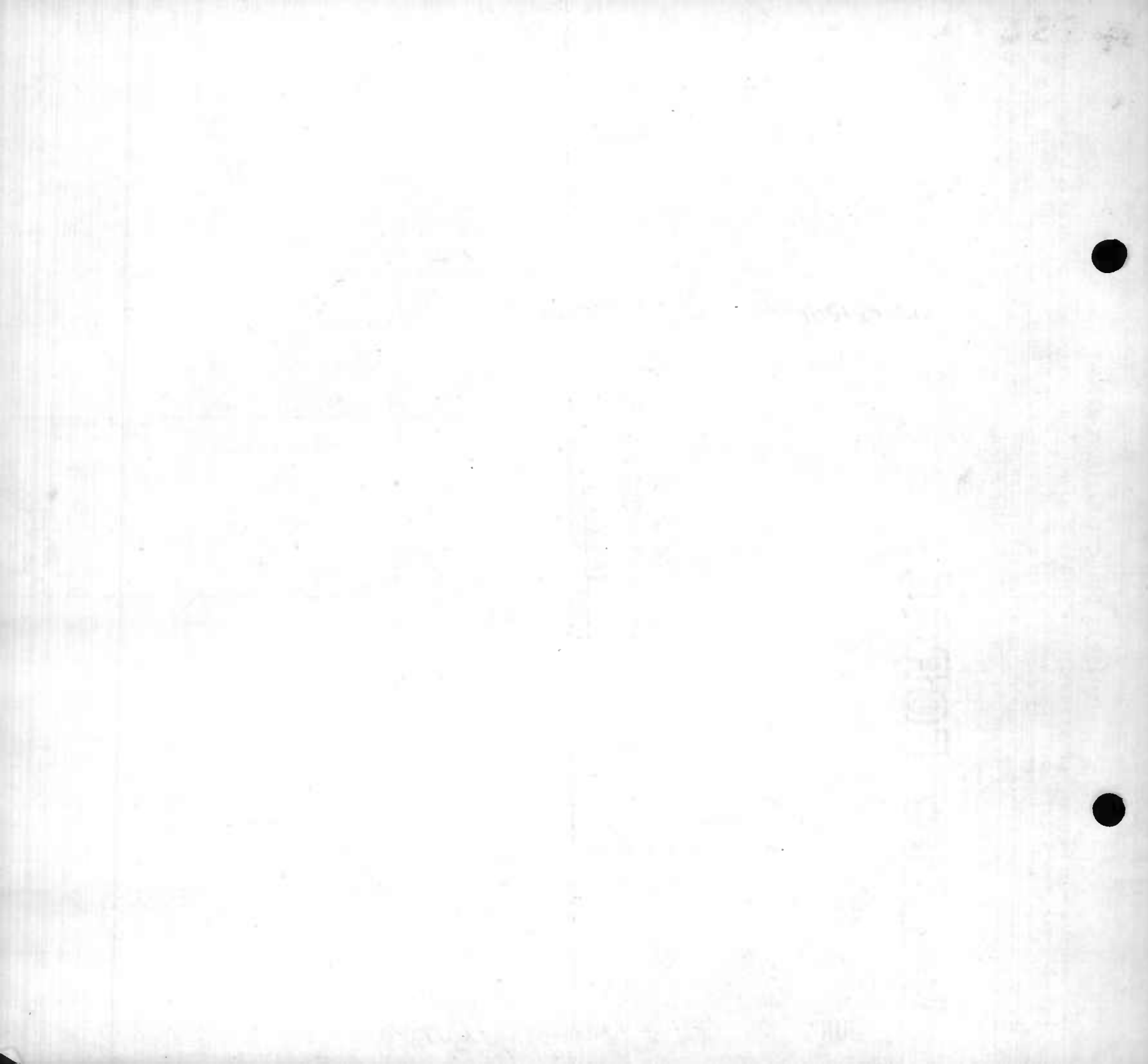
BIRTH NO. 67 5494		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 67 5494	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Robinson, MARY</i>			2. DATE AND HOUR OF DEATH <i>June 4, 67 11:10 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>36 FRANKLIN Square Hospital</i>			A. STATE <i>MARYLAND</i> B. COUNTY		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 19-02</i>		
			D. STREET ADDRESS (If rural, give location) <i>212 N. Gilmore St</i>		
5. SEX <i>F</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>2-27-23</i>	9. AGE (In years last birthday) <i>44</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Lynch</i>		14. MOTHER'S MAIDEN NAME <i>Ruth Fogle</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>		17. INFORMANT <i>JAMES R. Robinson 212 N. Gilmore St</i>	
18. <i>387.01</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Massive pulmonary atelectasis</i> DUE TO		<i>May 31-67 - June 4, 67</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Acute pancreatitis & a large pancreatic cyst</i> DUE TO		<i>11</i>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>MAY 31-1967</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>FAIR</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 3 1967</i> to <i>June 4 1967</i> , that (I) (we) last saw the deceased alive on <i>June 4 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Chull Hi Lee</i> M.D.				23B. DATE SIGNED <i>June 4-67</i>	
23C. PHYSICIAN'S NAME (Type) <i>CHULL HI LEE</i> M.D.				23D. ADDRESS <i>FRANKLIN Square Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>6-8-67</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto. Nat'l. Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 7 1967</i>		25B. NAME OF REGISTRAR <i>R. E. E. E. E.</i>	
25C. FUNERAL DIRECTOR <i>K. E. E. E. E.</i>		25D. ADDRESS <i>1348 Calhoun St.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5495	
27		67 5495		CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
		Esterella R. Dennis		6/3/67 10:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Maryland General Hosp		Md. Baltimore			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
Baltimore Md		3852 Falls Rd 13-07			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	Widow	02/19/25	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Sales Edg		Dept. Store		Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles M. Ray		Rachel Turnbaugh		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		2/3/10519		Harry Dennis son	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		pneumonia		10 days	
ANTECEDENT CAUSES		Aspiration			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		Fractured Hip		1 month	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Autism Moore Prosthesis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
5/11/67		Fractured Hip		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Pt. 5 Home		see above 13-07	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
5 10 67		While At Work <input type="checkbox"/> Nat While At Work <input checked="" type="checkbox"/>		Pt. fell	
22. I certify that (I) (this hospital) attended the deceased from 6/3 19 67 to 6/7 19 67, that (I) (we) last saw the deceased alive on 6/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
B. Ann Wood M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				6/3/67	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		June 67		Pikesville Md	
24D. LOCATION (City, town, or county) (State)		24E. NAME of REGISTRAR		24F. FUNERAL DIRECTOR ADDRESS	
Pikesville Md		Burger, E. J.		Burger Funeral Home 3631 Falls Rd	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 7 1967		Burger, E. J.		Burger Funeral Home 3631 Falls Rd	



A-536

67 5496

BALTIMORE CITY HEALTH DEPARTMENT

67 5496

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Howard Anderson

2. DATE AND HOUR PRONOUNCED DEAD

June 4, 1967

3:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4610 Lawn Park Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4610 Lawn Park Road

5. SEX

M

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

August 28, 1888

9. AGE (in years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

INSURANCE AGENT

10B. KIND OF BUSINESS OR INDUSTRY

INSURANCE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. Anderson

14. MOTHER'S MAIDEN NAME

IDA KOPP

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Eva J. Reimer - 4504 Hamanuth Ave.

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardio-vascular

(A) DUE TO

disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

June 4, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

6-6-67

23C. NAME of CEMETERY or CREMATORY

OAK LAWN Cem.

23D. LOCATION

(City, town, or county)

(State)

BALTO., MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 7 1967

A. E. Taylor

J. H. Miller - 2334 Jefferson St.

QUALITY ENERGY

ALABAMA POWER

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 5497

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH EATON, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

6-4-67

11:00 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

42 SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2813 Grantley Road 21215

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Student

8. DATE OF BIRTH

10-13-1952

9. AGE (In years
lost birthday)

14

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph M. Eaton, Sr.

14. MOTHER'S MAIDEN NAME

Dorothy E. Newman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Dorothy Newman 3530 Lucille Ave

18. E 98 IX

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot wound of head

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

In front of 2550 W. Cold Spring Lane

21D. TIME
OF INJURY
(APPROX.)

6

4

'67

11:00

PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

X

21F. HOW DID INJURY OCCUR?

Shot in head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-5-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

6-8-67

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat'l Cem.

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

JUN 7 1967

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Morton E. Dyer, F.H.

ADDRESS

1701 Laurens St.

10-10-55
10-10-55

10-10-55

10-10-55
10-10-55

10-10-55

10-10-55

10-10-55

10-10-55

10-10-55

W-300

67 5488

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

67 5488

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEO WHITE

2. DATE AND HOUR PRONOUNCED DEAD

6-1-67 7:45 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 PROVIDENT HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-09

D. STREET ADDRESS (If rural, give location)

3924 Carlisle Avenue 21216

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

May 22, 1897

9. AGE (In years last birthday)

70

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Construction Work

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Whiteville, N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Lillie Peacock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

Yes

?

16. SOCIAL SECURITY NO.

243-14-4078

17. INFORMANT

Mrs. Mildred Facen

122-34A Springfield Blvd.

18.

E983X

CAUSE OF DEATH

Queens, N.Y.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of cervical spine DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

South East corner of Eutaw Place and Whitelock Street

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) (Minute)

6

1

'67

7:45

PM

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Beaten up by two men

13-01

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-2-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

June 9, 1967

23C. NAME of CEMETERY or CREMATORY

Whiteville Chapel

23D. LOCATION

(City, town, or county) (State)

Whiteville, N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

JUN 7 1967

Relief 8. Fisher

Morton & Dyett F.H. 1701 Laurens St. Balto. Md.

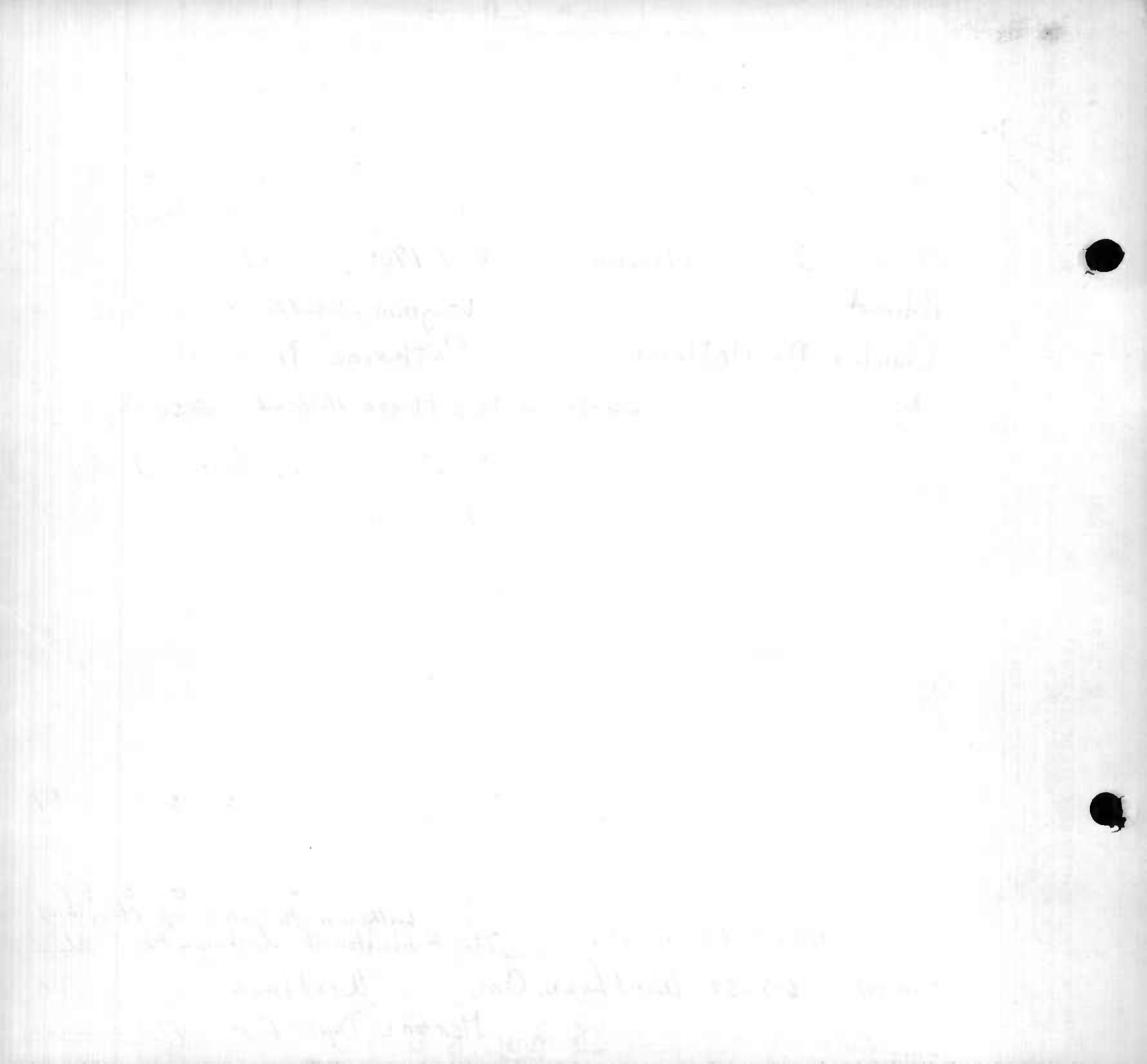
ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 11/11/01 BY 60322 UCBAW/STW

11/11/01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5499	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 5499</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) HOLLAND F. CHARLES</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 6-6-67 1-10 P.M.</p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE 302 Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 3026 Gwynn Falls Pkwy</p>		
<p>5. SEX Male</p>	<p>6. RACE C</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married</p>	<p>8. DATE OF BIRTH 8-9-1905</p>	<p>9. AGE (In years last birthday) 61</p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired</p>			<p>11. BIRTHPLACE (State or foreign country) Virginia, Woodland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>
<p>13. FATHER'S NAME Charles A. Holland</p>			<p>14. MOTHER'S MAIDEN NAME Catherine Norwood</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.</p>			<p>16. SOCIAL SECURITY NO. 225-34-0060</p>	<p>17. INFORMANT ADDRESS Mrs. Maceo Holland 3026 Gwynn Falls</p>	
<p>18. 331X I</p> <p>CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) Cerebral Haemorrhage (B) Hypertension (C)</p> <p>INTERVAL BETWEEN ONSET AND DEATH 1 day</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) No</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 6-5-1967 to 6-6-1967, that (I) (we) last saw the deceased alive on 6-6-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Anil M. Joshi</p>				<p>23B. DATE SIGNED 6-6-67</p>	
<p>23C. PHYSICIAN'S NAME (Type) ANIL M. JOSHI</p>				<p>23D. ADDRESS Lutheran Hospital of Maryland, 730 Ashburton St. Baltimore MD. 21216</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 6-8-67</p>		<p>24C. NAME of CEMETERY or CREMATORY Wood Lawn Cem.</p>	
<p>24D. LOCATION Wood Lawn</p>		<p>24E. DATE REC'D BY HEALTH DEPT.</p>		<p>24F. NAME OF REGISTRAR Robert S. Edwards</p>	
<p>24G. DATE REC'D BY HEALTH DEPT.</p>		<p>24H. NAME OF REGISTRAR</p>		<p>24I. FUNERAL DIRECTOR Marion E. Dyett F. H.</p>	
<p>24J. ADDRESS 1701 Laurens</p>		<p>24K. ADDRESS</p>		<p>24L. ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 67 5500	
<div style="display: flex; justify-content: space-between;"> B-630 67 5500 </div>					
<div style="display: flex; justify-content: space-between;"> BIRTH NO. M.E. CASE NO. </div>					
1. NAME OF DECEASED (Type or Print) Clarence Byrd			2. DATE AND HOUR OF DEATH 6-5-67 2:00P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217 </div> <div style="flex: 1; font-size: small;"> (If not in hospital or institution, give street address or location) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1527 N. Gilmer Street		
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH 3-18-07	9. AGE (In years lost birthday) 60 yrs.	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker			11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Golden Byrd			14. MOTHER'S MAIDEN NAME Annie Bell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-07-1204		17. INFORMANT Mrs. Bertha Byrd - Wife ADDRESS SAME
18. 203X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH PULMONARY EDEMA. CONGESTIVE HEART FAILURE MULTIPLE MYELOMA.		
19. DATE OF OPERATION 2			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from May 9, 19 67 to June 5, 19 67 , that (I) (we) last saw the deceased alive on June 5, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			21F. HOW DID INJURY OCCUR?		
23A. SIGNATURE A. Lizarazo			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-5-67
23C. PHYSICIAN'S NAME (Type) LIZARAZO			23D. ADDRESS M.D. 1514 Division Street Balto., Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-10-67	24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 7 1967		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Morton & Dyckhoff	
ADDRESS 1701 Laurens St					

MULTIPLE MYELOMA.
CORRELATE HEART FAILURE
PULMONARY EDEMA.

Anemia.

LISARASO
A. Lisaraso